

Counting pains and creating pathologies:
Exploring the role of quantitative operationalization in the medicalization of grief

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Thesis

Submitted to the Faculty of the
Graduate School of Vanderbilt University
in partial fulfillment of the requirements
for the degree of

MASTER OF ARTS

in

Medicine, Health, and Society

August 12, 2022

Nashville, Tennessee

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Acknowledgements

Even as (or, because) I hesitate to think of this as a product, I am deeply grateful for the generosity of many who have shaped, and continue to, this process of learning. First, thanks to the members of the committee for your inspiring, generous, and helpful mentorship, and for teaching me more than I can say.

Thank you, Dr. Stark, for your patient guidance in each stage of this process, for your fantastic ideas and resources, your generosity with time and encouragement, and your wonderful advice at every step and stumble. Even more than these, thank you for your inspiring model of purposefulness and intentionality in so many spaces, for your gentle reminders to ground theories in realities and thoughts in hope, and for the meaningful and generous thoughtfulness that you model in your teaching, speaking, doing, and being. I will hold close your wisdoms and lessons, and I can't articulate my gratitude for the chance to learn from you this year. Thank you.

Thank you, Dr. MacLeish, for your generosity with time, wisdom, thoughtfulness, and helpfulness. Your guidance and suggestions throughout this year have shaped this process tremendously. I'm grateful for your warmth and patience with many questions and I'm inspired by the grounded intentionality you model in conversation, teaching, and research. For your mentorship, help, and all that you do, Thank you.

Thank you, Dr. Viego, for passionately and warmly introducing me to a new set of disciplines, thinkers, and thoughts in 2019, for creating a space of learning that was so meaningful, inspiring, and joyful. I'm grateful for your continued generosity with time, advice, patience, and mentorship since. You've laid the roots for this process and helped each step. Thank you.

Thank you, Dr. Petty and Dr. Callahan-Kapoor, for your resources, your patience with questions and confusions, and your generosity with time and expertise. Much gratitude to many cohort-mates in MHS – each of your passionate commitment to so many important causes is incredible, and it has been such a gift to learn from you. And, to the patient Inter Library Loan staff who searched for and uploaded 40+ articles from a journal on death and dying, Thank you.

I am also immensely grateful for professors in undergrad whose teaching, kindness, and inspiring work have nudged me and will continue to inform learning, doing, and being – Professors Gheith, Hollowell, Hariri, Barfield, Kinghorn, Safi, Mackey, Mignolo, Chow, and Bassiri, Thank you.

Moreover, this process is inspired greatly by and grounded in the lived example of many. I am indebted to the stunningly courageous and faithful work of Jean Gakwandi and so many others in Kigali, who foster spaces of mourning and care every day. Thank you for welcoming me into the Solace family and for challenging me so deeply and gently.

Thank you also to the community at the Center for Grieving Children in Portland. Jamie, Florence, Justine, Claudette, and Marie, your daily enactment of being with, creating spaces for, and welcoming the expression of emotion among the kiddos we're so lucky to work with is deeply touching and important. Thank you for sharing such wisdom and warmth with a New Mainer all year. Your work within the walls of the Center and beyond is a treasure and a gift.

Finally, thank you to my parents and siblings. Mom and Dad, Josh and Jesse, Rachel and Stephen, you each do such meaningful and important work of Being with and caring for the people and environments around you, and you inspire and ground me each day. For your conversations, care, ministry, and so much more, Thank you.

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Introduction

“Could you be suffering from Complicated Grief Disorder?” (Carranza, 2022). Answer nine questions and PsyCom will let you know (Carranza, 2022). In an article estimated to take less than one minute, TherapyChat presents a “grieving test [to] find out if you have overcome your loss” (“Grieving TEST,” 2019). An entertainment site informs viewers that “sorrow is a very personal and nuanced emotion, and everyone grieves differently. Also, you must try to play this *What Stage Of Grief Am I In* quiz” (Stratton, 2021). The Health News department of *U.S. News and World Report* examines “How Grief Harms the Body” (Priedt, 2022). The medical site Healthline promises to tell you “What ... You Need to Know” about “The Stages of Grief” (Holland & Lawrenz, 2022) and *The Guardian*’s Health and Fitness department explores “How long is too long to mourn?” (Saner, 2022). These headlines iterate important truths: grief can be a tremendously painful experience, and it is important to give space, care, and, at times, clinical treatment to grieving individuals. However, the very presence of these quick quizzes and tips throughout popular culture and health discourse is not inevitable, and it illustrates the significant transformations that have occurred in conceptualizations of grief since 1917, when Sigmund Freud wrote that “it never occurs to us to regard [mourning] as a pathological condition and to refer it to medical treatment” (Freud, 1953, p.243). These transformations are the focus of the current project.

Within the past century, the discipline of psychiatry has medicalized grief, redefining it through symptoms-based articulations and claiming it as an object to be examined and treated in medical spaces (Bandini, 2015). Moreover, modern healthcare systems are run not only on the assumption that experiences like grief can be articulated in the language of the clinic, but also that they are measurable: scales drive research into disorders, they assign labels that guide treatments, and they serve as the common language between physicians and patients (Panagiotakos, 2009). For this reason, intertwined with its medicalization, grief was also operationalized, and precursors of the above quizzes were developed. As such, once it was entrapped in psychiatric discourse amid cultural desires and institutional priorities to manage and explain, grief transformed from an uncontrollable and undeniably painful human experience into an object to be counted, tracked, and

treated. The purpose of this paper is to explore the path of grief through these processes of medicalization and operationalization in the moments that these cultural desires were blossoming.

Medicalization is defined as the “process by which certain behaviors and conditions are defined as medical conditions or disorders,” subject to clinical measurement and treatment (Bandini, 2015, p.347; Stegenga, 2018). Medicalization has benefits in the U.S. context, such as creating important avenues for support through diagnostic-based insurance and research funding (Bandini, 2015; Stegenga, 2018). However, it also has significant drawbacks, including increasing stigma, legitimizing the decontextualized chemical treatment of symptoms, and, I argue, creating reductive categories for categorically incommensurable experiences like those of pain (Bandini, 2015; Stegenga, 2018). Some scholars argue that the cultural power of psychiatric expertise in the Global North¹ has grown to the extent of asserting control over everyday life, medicalizing previously non-pathological experiences (Rose, 2019; Stegenga, 2018). In the medicalization of grief, mourning has, to some extent, been denied normalcy, as well as access to traditional modes of expression and meaning-making (Granek, 2012). This is significant because, rather than being cared for within a community, individuals who survive losses are expected to report symptoms and receive treatments within clinical spaces (Bandini, 2015; Stegenga, 2018; Granek, 2012).

Our culture prioritizes ‘objectivity’ in medicine and views quantification as a tool for ensuring objectivity (Hacking, 1990; Merry, 2016). For this reason, a key mechanism of medicalization is operationalization, the creation of a definition and set of “objective criteria” through which an expert can determine the severity of an experience, and thus if a patient, for example, fits into a certain diagnostic category (Parnas & Bovet, 2014, p.193). In psychiatric diagnoses, operationalization often takes the form of quantitative measures, with diagnosis being determined on the basis of a set cut-off score (Parnas & Bovet, 2014; Horwitz & Wakefield, 2007). While some psychologists and researchers argue for the practicality, efficiency, and efficacy of operationalized scales, and for their importance in predicting outcomes or making diagnoses (Pies, 2013; Horwitz & Wakefield, 2007; Arshad & Muazzam, 2016; Clark et al., 2005-2006), others have

¹ Here, ‘Global North’ refers to historically – and presently – colonizing nations, generally North of the Brandt Line and equator, noting great heterogeneity even within these divides (Adams et al., 2019).

suggested that the operationalization of psychiatric phenomena, and particularly the wide dissemination of operationalized measures, has overly “extend[ed] medical authority,” identifying as pathology that which most do not “believe is disorder” and instituting treatment among individuals who do not seek help (Horwitz & Wakefield, 2007, p.146). Building on these latter views, I argue that operationalized measures for grief are harmful in that they decontextualize the medicalized conceptualization of an inherently non-pathological human experience.

It is important to examine the decisions made in introducing and carrying out the processes of medicalization and operationalization in order to understand more fully how the possibilities for the present conceptualizations of grief – including a recently official diagnosis for pathological grief and the dominance of methods of decontextualized symptom network analysis – were created (Kecmanovic, 2021; MacCallum et al., 2021). Because of the iterative and communal nature of science, each claim in grief’s history contributed to the creation of a grief that is measurable, pathologizable, and treatable, and it denied other conceptions (Kuhn, 1996). The power of science, and particularly of quantitative methods, shapes realities that are perceived as objective, even as it prevents consideration of modes of understanding and treating grief outside of clinical spaces, cultural and local manners of expressing grief that exist beyond psychiatry’s ‘normal,’ and populations and issues that are unacknowledged within medical hierarchies of knowledge-power (Merry, 2016; Horwitz & Wakefield, 2007; Berlant, 2011). These decisions make real the possibility of a pathological grief being distributed as science in nine-question internet quizzes that guide to chemical treatment individuals identified as abnormal (Stegenga, 2018; Bishop, 2011).

To locate the contingencies that directed the path to dominant conceptualizations of and medical approaches to grief in the present day, we must study the moments that grief came to be considered not only medical, but also quantifiable. While literature exists on the medicalization of grief, there is a silence regarding the role of operationalization in these narratives. The current project seeks to explore this gap, using the methods of critical discourse analysis to examine the content of and power relations involved in conceptualizations of grief in the psy-disciplines, Nikolas Rose’s term for fields, such as psy-chology and psy-chiatry, that examine and regulate the “self” (Rose, 1998, p.2). The project focuses on the years surrounding American psychiatry’s

formal adoption of operationalization in 1980. Toward this end, the data consisted of articles about grief that were published between 1975 and 1995 in three respected and relevant psy-discipline journals. Primary questions guiding analysis included: How was grief defined between 1975 and 1995? How was the creation of quantitative measures for grief justified? What patterns exist in motivations for quantification and measurement? Does the discourse around grief produced in this period, particularly 1) grief as pathology and 2) grief as measurable, inform our understandings of the changing societal priorities and conceptualizations in these decades?

It is important to acknowledge the suffering entailed in the grief experience, and to give space and support to people experiencing grief. In this research, I do not seek to minimize the experience of grief, nor to dismiss the importance of medical treatment: grief and related experiences are incredibly painful, and therapeutic and psychopharmaceutical treatments (and thus operationalized diagnoses and insurance systems) can be crucial in managing symptoms and ensuring safety. I hope to emphasize the necessity of not only studying grief, but also examining how grief is studied. Moreover, I do not aim to propose an alternate way of articulating or treating grief – in fact, I write from the position that there is necessarily no ‘one’ way, and with the understanding that previous conceptualizations of grief were likely as imperfect as present. In this research, my goal is to shed light on the processes producing the current conceptualizations in order to locate the borders of psy-discipline’s ‘grief’ and to imagine what types of experience and expression were excluded or pathologized in this articulation.

The following section includes an overview of literature relevant to the paralleling histories of medicalization and operationalization in psychiatry and as they relate to grief, as well as a brief discussion of the modern construction of grief. I then describe the coding methods I used to analyze the discourse and learn about dynamics of power involved in psy-discipline articulations of grief. The results section contains a brief description of the data and discussion of the trends that arose in each group of codes. In the discussion, I argue that the data suggest that conceptualizations of grief became increasingly medical, multidimensional, and pathologized. I close with an examination of various concepts and theories as they inform an understanding of operationalization’s role in these processes, and I argue that measures for grief serve(d) as colonial

and decontextualizing tools of the clinical gaze and dynamically shape(d) the medicalization of grief.

Literature Review

This section includes a review of literature intending to trace the paralleling (and intertwined) histories of the medicalization of grief, the shifting of psychiatry to operationalized models, the operationalization of grief, and the modern context of grief studies. Though this review seeks to present multiple perspectives and tell a contextualized history of diagnostic and methodological development, I must note that sources and theories included primarily stem from a position of critical psychiatry, a “broad” field that “takes exception to some or all of the current dominant premises and paradigms [in psychiatry] and endeavors to explore the implications of various critiques” (Moncrieff & Steingard, 2019, p.1) Within this discipline, the present review is guided by key tools and methods of scholars such as Michel Foucault and Ian Hacking. Therefore, I aim here to establish a brief a history of a concept now taken as inevitable or discrete, a genealogy of grief and its operationalization.

Medicalization of Grief

To understand present conceptualizations of grief in the Global North and the events and decisions that contributed to this paper’s period of analysis, this portion of the literature review will briefly consider definitions of and approaches to psychiatry and grief prior to the 1970’s. This is no way a culturally or historically full history: the goal of this section is to trace the movement of grief from a feature of nature or culture to the pathological object of medicine. As Sociologist Allan Horwitz and scholar of mental health Jerome Wakefield write, current conceptualizations of mental health and illness may seem “sensible,” and the path to them inevitable, but it is important “to understand the problems with [current diagnostic structures] and to recognize the choices [they] represent” by exploring the historical moments that produced them (Horwitz & Wakefield, 2007, p.53). In identifying a few key figures and moments of this narrative, I hope to give

sketches to the broader shape of grief's history, while also being aware that there are many nuances not included here.

Normal Reactions: pre 19th Century

In his recent history of the DSM, Allan Horwitz traces the roots of psychiatry to Ancient Greece, wherein the intersections of the environment, the individual, and society determined the balance of humors, which in turn shaped the expression of pathologies (Horwitz, 2021). Melancholia, for thousands of years, was an experience of extreme quiet, anxiousness, and depression loosely connected to an excess of black bile – an imbalance in the body as shaped by the threefold intersection (Horwitz, 2021). Scholars note that there was little specificity of causality or nosology beyond these broad categories and theories, and that treatment of mental illness (“‘madness’ or insanity,” Horwitz, 2021, p.15) was more concerned with sheltering patients and shaping a “healing environment” (Whooley, 2019, p.52; Horwitz, 2021) than implementing any particular protocol (Horwitz, 2021; Whooley, 2019). As such, early spaces of treatment for the mentally ill did not make use of diagnosis beyond bureaucracy and institutional organization (Horwitz, 2021; Whooley, 2019).

In the 18th Century, the landscape of psychiatry began to change (Horwitz, 2021). French psychiatrist Philippe Pinel conducted foundational work in this time, significant to and representative of disciplinary trends (Horwitz, 2021). Using the model of medical nosologies, Pinel applied “analytical investigation” in the construction of a classificatory system (Pinel, 1806, p.1; Horwitz, 2021). To make sense of the varieties of “insanity” (Pinel, 1806, p.3) present in clinical settings, he expanded the theories of mental illness according to many categorical and situational factors, from symptoms to seasons (Horwitz, 2021; Pinel, 1806). Unlike later scholars, Pinel wrote in a way that was attuned to the details of individual cases (Pinel, 1806). He argued that patients present “an endless variety of character” and must not be treated with abuse or medication, but rather in a manner that is “mild” and moral (Pinel, 1806, p.108). Horwitz affirms the connections between Pinel’s writing and practice, emphasizing that these classifications, like most before the 20th Century, were limited only to “external signs and symptoms,” and that treatments continued to be guided by individual differences (Horwitz, 2021, p.16).

Narrowing focus to conceptualizations of grief amid this shifting psychiatry (Granek, 2010, p.46), scholar of the history and theory of psychology Leeat Granek focuses her historical narrative on “people who have studied the phenomenon of grief within a relatively close paradigm to the social sciences” (Granek, 2010, p.49). Both Granek’s and Horwitz’s histories trace the path of psychiatry to a scholar working in the same era as Pinel, American psychiatrist Benjamin Rush (Granek, 2010; Horwitz, 2021). Rush crafted a model under which “almost all ailments could be reduced to manifestations of the single disorder of fever,” and “physicians strove to heal the whole person rather than provide some distinct remedy for a specific problem” (Horwitz, 2021, p.15). Rush’s conceptualization of grief reflected this orientation (Granek, 2010; Horwitz, 2021). He did not see grief as an illness or pathology, but rather as a “normal reaction” (Granek, 2010, p.49), an incredibly painful experience that touches all humans at some point, the expression of which is shaped by situation and cultural context (Granek, 2010; Gravesen & Birkelund, 2021). Horwitz and Wakefield affirm this notion, writing that, in the 18th Century psychiatry of Rush and his colleagues, emotional pain was to be diagnosed as melancholia only when it came “without cause” (Horwitz & Wakefield, 2007, p.61). This meant that, even as practices changed drastically between the psychiatry of Hippocrates and that of Rush, grief was consistently accepted as painful and yet inherently non-pathological, and as such, was not an object of psychiatric expertise (Horwitz & Wakefield, 2007; Gravesen & Birkelund, 2021; Granek, 2010).

The Examination of the Everyday and the Birth of the Clinic: 19th and early 20th Centuries

Two key schools of thought were developed in the 1800’s and early 1900’s that concern our understanding of grief and broader psychiatric experiences. The first, led by Emil Kraepelin, began with the transformation of medical discourse as the science of bacteriology was born in the late 1800’s, with some scholars placing increasing emphasis on diagnostic specificity and criticism of Pinel’s categories growing (Horwitz, 2021). The second, led by Sigmund Freud, brought a causal understanding to psychopathology (Horwitz, 2021). Each of these transformations had significant impacts, and they wove together to shape the power and position of psychiatry in everyday life.

Kraepelin and Freud. Research on syphilis inspired “clinicians ... to shift their attention away from symptomatic presentations to the course and outcome of mental disorders” (Horwitz, 2021,

p.17). German psychiatrist Emil Kraepelin, now considered the father of modern psychiatry, enacted this turn by creating a new diagnostic system in 1883 (Horwitz, 2021; Horwitz & Wakefield, 2007; Shorter, 1997). He emphasized the development of scientific methods of psychiatric classification and the discovery of consistent physical bases for psychiatric experiences (Granek, 2010; Granek, 2012; Horwitz & Wakefield, 2007; Horwitz, 2021). Further, Kraepelin introduced the idea that psychiatric categories were discrete and definable, with specific origins, courses, and endings (Horwitz, 2021; Parnas & Bovet, 2014; Horwitz & Wakefield, 2007). He shaped the discipline significantly, particularly in orienting the focus of expertise away from individual differences and situations and toward illness processes (Horwitz, 2021).

Second, working in decades that overlapped with Kraepelin, Sigmund Freud parted from the work of classifying and searching for the biological bases of neuroses and developed psychoanalysis, a method of examination and treatment based in “psychological dimensions” (Whooley, 2019, p.102; Horwitz, 2021). Particularly in the early 1900’s, Freud came to understand symptoms as symbolic manifestations of “unconscious psychic conflicts” (Horwitz, 2021, p.19; Whooley, 2019). He argued that all humans could experience these conflicts, and thus the psychoanalytic endeavor was not one of defining pathologies, but identifying and addressing “specific manifestations of neuroses” (Whooley, 2019, p.102). Freud developed theories concerning many experiences and pathologies, and his work significantly shaped the content and structure of early 20th Century American psychiatry (Horwitz, 2021; Granek, 2010).

Most relevant to our focus is Freud’s work on mourning and melancholia, published in 1917. Here, Freud outlined the differences between mourning (in the German, ‘trauer,’ which refers to “both the affect of grief and its outward manifestation;” Freud, 1953, p.243) and melancholia, a pathology that aligns more with modernity’s depression. Freud argued that mourning, while often manifesting in “grave departures from the normal attitude to life,” is never to be seen or treated as a pathology (Freud, 1953, p.243). He wrote that “we rely on its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful” (Freud, 1953, p.244). While describing the symptoms of mourning and melancholia as sharing significant overlap, Freud emphasized that the mourning process is one of libidinal detachment from the lost object – a process

that might even include such symptoms as hallucinations of the lost – and that the ambivalence or absence of a (conscious) loss is a defining feature of melancholia (Freud, 1953). He also argued that only melancholia entails symptoms related to self-regard, such as guilt, or tendencies to transition into states of mania (Freud, 1953). Freud also introduced the idea that the recently bereaved needed to “give up the object by declaring the object to be dead and offering the ego the inducement of continuing to live” in the process of grief work (Freud, 1953, p.257; Granek, 2010; Gravesen & Birkelund, 2021).

I must emphasize again that, even though Freud identified grief, previously inseparable from concepts of the communal and cultural, as an individual experience, and though he brought the experience, previously banal, into clinical considerations, Freud was intentional to describe mourning as non-pathological and insist that it not be treated (Granek, 2010, p.52; Gravesen & Birkelund, 2021; Leader, 2008).

Clinical Gaze and Human Kinds. While shaping the field of the psy-disciplines in different ways, both Kraepelin’s and Freud’s methods left significant imprints on later – including modern – iterations of care. In his 1909 lectures at Clark University in the United States, Freud introduced the orientation of psychoanalysis by arguing that all aspects of human life, even the seemingly banal (including experiences of grief), could be indicative of health or pathology, and thus should be analyzed by psychoanalytic expertise (Granek, 2010; Whooley, 2019). This marked significant cultural transitions, namely the birth of the “mental hygiene movement,” which brought examination of social experiences into the realm of experts and, as such, broadened the focus of psychiatry onto “the general well-being of the lay public” (Granek, 2010, p.57; Zalnora & Miežutavičiūtė, 2016).

This opening up of the everyday to psychoanalysts, some argue, echoes a significant shift that occurred in medical techniques and understandings between mid-18th and mid-19th Centuries (Granek, 2010; Foucault, 1994). In his text *The Birth of the Clinic*, philosopher and intellectual historian Michel Foucault identifies the transformation of bodies in this time “into a world of constant visibility” (p.x), by which medical discourse came to be considered newly “rational,” objective, meticulous, and valuable (Foucault, 1994, p.xi). Significantly, the “medical gaze” (also referred to as

clinical gaze) that was developed, the new way of examining and understanding medical phenomena, was one wielded by – and reinforcing the power of – medical expertise (Foucault, 1994, p.89).

One product of this process is the transformation of experiences and behavioral phenomena from a “natural kind,” defined by philosopher of science Ian Hacking as phenomena that appear – and have always appeared – in nature, into a “human kind” (Granek, 2010, p.47; Hacking, 1995). Citing Hacking, Granek defines a ‘human kind’ as a conceptual category constructed to organize formerly ‘natural kinds’ into systems of classification, particularly within the social sciences (Granek, 2010; Hacking, 1995). Such systems are then used in the social sciences to classify and “sort people, their actions, and behaviors in various categories” (Granek, 2010, p.47; Hacking, 1995).

The psy-disciplines therefore acquired a practice not only of examining the natural and visible, but, through expertise as evidenced by both psychoanalytic theories and Kraepelinian classifications, one of “calculating,” defining, and shaping the meanings and presentation of phenomena, of creating ‘human kinds’ (Foucault, 1994, pp.89-90; Hacking, 1995). The identification, understanding, and treatment of illness – the ability to transform in/visibility into linguistic explanations – became a practice for only the clinician, “the sovereign power of the empirical gaze that turns [unknown] darkness into light” (Foucault, 1994, pp.xiv). In sum, the birth of modern medicine and, later, the integration of these methods into the psy-disciplines, brought both new power to the wielders and clinical expertise and new ways of examining and understanding medical phenomena (Foucault, 1994). Regardless of Freud’s intentions, the groundwork that he laid in psychoanalytic theory, coupled with the cultural movements in medicine and Kraepelin’s transformation of psychiatry into a science of classifying, proved a significant step in the history of previously unexamined human experiences, including grief.

Creating Pathologies: 20th Century

This re-formation of the clinical gaze, some argue, was only strengthened over the following decades as the psy-disciplines came to hold an increasingly prominent position in the U.S. In the wake of the significant trauma identified among soldiers following World War I, the professions of the psy-disciplines gained a place of value in the medical hierarchy, in the minds of citizens, and in the culture of the U.S. (Whooley, 2019; Leader, 2008).

Sociologist Owen Whooley argues that this surge in psychiatry (the dominant mode of which was psychoanalysis) was only strengthened during World War II, when the trauma of the war, coupled with the fleeing of many Jewish psychoanalysts to the U.S., lent the field both increased presence and “a renewed sense of purpose” (Whooley, 2019, p.101). Whooley writes that, between Freud’s visit to the U.S. in 1909 and the end of World War II in 1945, “American psychiatry was transformed into a bastion of psychoanalysis” (Whooley, 2019, p.96). This inter- and post-war context was also a moment of modernism, urbanization, and technical-scientific revolution, and cultural value was increasingly placed in “scientific rationality, reason, observations, and a belief in continuous progress” (Granek, 2010, p.48; Gravesen & Birkelund, 2021; Binkley, 2011). And, Whooley writes, “American psychiatrists ... modified [Freud’s ideas] to fit their needs” (Whooley, 2019, p.101). As such, psychiatry was reinvigorated in the U.S. as a “sophisticated system” by which the root causes and mechanisms at work in pathology could be discovered and addressed (Whooley, 2019, p.105). Many psychological experiences in the early- to mid-20th Century were reconceptualized in psychodynamic theory, bringing with them goals of efficiency and progress (Granek, 2010).

While articulations of psychiatry’s history in the era of the world wars vary, consensus suggests that at least two notable changes took place in this period: 1) the narrowing of the unit of examination within the psy-disciplines to the individual, and 2) the increase in emphasis on scientific specificity and progress (Leader, 2008; Gravesen & Birkelund, 2021; Whooley, 2019). These changes can be seen at work in reconceptualizations of grief in the first half of the 20th Century (Granek, 2010).

First, the introduction of these two changes contributed to the idea that there is one ‘rational’ ‘way’ of behaving in certain contexts and situations, including after a loss (Granek, 2010). Further, Granek notes that a key refiguration of grief likely born from these cultural values was the idea that it is a process that requires active work on the part of the griever (Granek, 2010). She points out that this departure to justifications of “grief work” and ideas that grief is a process that can become pathological, while often described as rooted in Freud’s theories, is in fact a direct contradiction to the (aforementioned) grounds he presented in mourning and melancholia (Granek, 2010, p.52). Building on these departures, the first scholar to present grief as something that can be pathological was Helene

Deutsch (Graneek, 2010). In her 1937 essay 'The Absence of Grief,' Deutsch describes pathological grief as that which is absent, unexpressed, "excessively intense, even violent, or ... unduly prolonged to the point of chronicity" (Graneek, 2010, p.52; citing Deutsch, 1937, p.12). Graneek emphasizes the contrast that Deutsch introduces between a pathological and a "normal course of mourning," significant in that it was the first publication to conceive of grief as having a bounded "normal" (Graneek, 2010, p.52; Deutsch, 1937).

This movement of grief into the realms of classification and pathologization was enacted most fully by Erich Lindemann (Graneek, 2010). Lindemann worked with individuals bereaved in the Coconut Grove nightclub fire, in World War II, and at a local Boston hospital (Lindemann, 1944). He developed a thorough (perhaps Kraepelinian) explanation of the symptomatology and course of normal and "morbid" grief reactions (Lindemann, 1944, p.144). He described "pathognomonic" grief as involving "(1) somatic distress, (2) preoccupation with the image of the deceased, (3) guilt, (4) hostile reactions, and (5) loss of patterns of conduct" (Lindemann, 1944, p.142). In concluding his analysis, Lindemann wrote that the severity of an individual's grief experience may be predicted based on various situational and individual factors, and that "proper psychiatric management of grief reactions may prevent prolonged and serious alterations in the patient's social adjustment, as well as potential medical disease" (Lindemann, 1944, p.147). Graneek points to this moment in the discourse as particularly significant in that grief was conceptualized as a psychiatric category and the "explicit intervention of psychiatrists" was urged to ensure the proper performance of patients in their 'grief work' (Graneek, 2010, p.58; Lindemann, 1944).

Though greatly simplified, this history of grief, from expected communal occurrence, to individual analyzable object, to categorizable and necessarily medical experience, evidences the beginning of its slow path toward medicalization in – and because of – the culture of the Global North. There are not consistent narratives of the ways that these works of Deutsch and Lindemann, and the broader cultural changes that produced them, played into the diagnosis and treatment of normal and pathological grief in clinical spaces. In general, this period in psychiatry is understood as one lacking in uniformity across the U.S. (Horwitz, 2021). The first two editions of the DSM, while seeking to bring cohesion to understandings of psychopathology, were not hugely influential on U.S.

culture, or even on the culture of psychiatry (Horwitz, 2021). For this reason, while we can hold these trends and examples as significant in shaping psychiatry as a science of diagnosing and treating the individual, and in shaping grief into something which can be pathological and may require the expertise of the psy-disciplines, we must recognize that there were likely many practices at work in facing or facilitating grief. This history pauses in the mid-20th Century, which I argue is a period marked by a rapid increase in grief's medicalization via operationalization.

Introducing Operationalization

A key mechanism of medicalization is operationalization, a process that builds on the constructed boundaries between 'normal' and 'pathological' by creating functional definitions, symptomatology, and scales (frequently quantitative) for 'human kinds' (Hacking, 1995; Hacking, 1990). The main goal of this section is to give a brief overview of literature on operationalization, describing its entry into and role in psychiatry and discussing key findings on the motivations for and implementations of this process. I will explore the history of operationalization, both practical and theoretical, in an effort to better understand how it came to be considered best practice in psychiatry and what implications it entails, particularly on historically incommensurable experiences like grief.

Revolutions in DSM-III

As discussed, Emil Kraepelin first developed diagnostic categories with motivations for applying a "strictly biomedical framework" to psychiatry (Horwitz & Wakefield, 2007, p.75). The psy-disciplines, especially in the U.S., wandered with varying alignments toward these goals through the eras of Freudian psychoanalysis, ego psychology, and psychodynamic practices (Whooley, 2019). By the 1960's and 1970's, the field of psychiatry was lacking in uniformity and in "diagnostic reliability and validity" (Whooley, 2019, p.121). Moreover, the discipline was facing challenge from LGBT+ and gender equality movements, as well as the broader antipsychiatry movement, which critiqued the diagnoses in the DSM (i.e., homosexuality) and psychosocial model of the field as unethical, disorganized, and inferior to more medical models (Parnas & Bovet, 2014; Horwitz & Wakefield, 2007; Horwitz, 2021; Whooley, 2019). This criticism added to pressures on psychiatry presented by the institutional intertwinements of the U.S. medical system with federal agencies,

insurance systems, and pharmaceutical organizations, motivating calls for a new systematic mode of diagnosis and biomedical care (Horwitz, 2021; Whooley, 2019).

Bombarded with these criticisms, psychiatry sought to reconstruct itself as “a branch of medicine” using “modern scientific methodologies” to “investigate the causes, diagnosis, and treatment of [discrete] mental illnesses” (Whooley, 2019, p.168, citing Blashfield’s nine tenets of psychiatry). It thus becomes seemingly inevitable that psychiatry, in seeking biomedicalism for cultural respect and systematic structure for institutional recognition, might adopt that which biomedicine took on in seeking rationality and empiricism: models of classification based in quantification (Horwitz & Wakefield, 2007; Hacking, 1990; Horwitz, 2021).

In what Whooley calls “the Neo-Kraepelinian revolution,” the discipline became one “of the book,” placing significant emphasis on the third edition of the American Psychological Association’s Diagnostic and Statistical Manual (DSM-III, 1980), not only for medical explanations of disease, but also as a guide for the diagnostic process (Whooley, 2019, p.164). The Task Force for the development of this new DSM was led by psychiatrist Robert Spitzer (Whooley, 2019; Horwitz, 2021). Spitzer used the model of the newest edition of the International Classification of Diseases (ICD-9) to construct a systematic tool for both research and clinical settings (Horwitz, 2021; Shorter, 2008). The number of diagnoses increased from 182 to 265, and DSM-III explicitly shifted away from descriptive or theoretical text toward a focus on biological and etiological explanations (Gaines, 1992; Kinghorn, 2013).

Before this publication, mental health professionals and researchers held a wide range of conceptualizations of illness, and diagnosis was a clinician-led process of matching patient experiences to a set of prototypes (Parnas & Bovet, 2014). When understanding of mental illness acquired the biomedical model its protestors and institutional intertwinements demanded, the diagnostic process transformed from “an interpretation of symbols of distress” to “a reading of signs of disease” (Gaines, 1992, p. 9; Kawa & Giordano, 2012). This new nosology introduced operationalization and quantitative evaluation as status quo for psychiatric diagnosis (Parnas & Bovet, 2014; Horwitz, 2021; Horwitz & Wakefield, 2007; Shorter, 1997). By initiating a process of

“identifying a sufficient number of relevant symptoms and signs, representing allegedly ‘operational criteria’” of a psychiatric classification, DSM-III brought, Parnas and Bovet argue, “the most profound transformation of clinical and scientific psychiatry in the twentieth century” (Parnas & Bovet, 2014, p.190). This transformation is significant because it marks the enactment of operationalization, and is thus the centerpiece for the moment of focus in this project (1975-1995).

Why Operationalization?

Histories of psychiatry have shown us the broader cultural impulses and influences on the integration of operationalization into diagnostic methods. Meanwhile, other scholars shine light on underlying movements driving the very valuation of operationalization. I will briefly explore these writings in order to more fully understand why the process of quantification seems the inevitable decision when faced with legitimizing psychiatry. I will also discuss a few instances in which these same motives for operationalization also contributed to the pathologization of grief.

Control via quantification. Building on the histories of the 1900’s as a time of compounding cultural emphases on rationality, empiricism, and (biomedical) science, Ian Hacking traces cultures of statistics and measurement in his book *The Taming of Chance* (1990). Hacking argues that these social priorities influenced the natural sciences, rather than the reverse (Hacking, 1990, p.1). He claims the “imperialism of probability,” the need to control uncertainty through measurement, analysis, and prediction, was initially brought on with mechanisms of productivity, timekeeping, etc., introduced in the Industrial Revolution and re-emphasized in the early 1900’s (Hacking, 1990, p.5). This imperialism took hold and came to be prioritized in the medical sciences (Hacking, 1990).

Anthropologist Sally Engle Merry builds on this narrative, writing that quantification, particularly that of complex and “murky” social concepts, is “seductive” (Merry, 2016, p.1). Echoing Hacking, Merry describes how the process of quantification, in making “simple” and “accessible” these concepts, appeals to human tendencies to organize and understand the world around us (Merry, 2016, p.1). They “satisfy the unease and anxiety of living in a complex and ultimately unknowable world” (Merry, 2016, p.4). While Merry cites these reasons in exploring measures’/indicators’ path to power among research on equality and human rights, I argue that this seductiveness is true in the “murky” spaces of health, psyche, and behavior, over which the medical and psy-disciplines claim

control via knowledge production (Merry, 2016, p.1). The cultural imperialism and seductiveness of quantification, therefore, blossoming in the era of the psy-disciplines' affirming their expertise, help us to make sense of the swift adoption of operationalization.

Neoliberalism and Health. In addition to these disciplinary dynamics and cultural values, historians have identified intertwined cultural movements at work in the era of DSM-III's development and crafted arguments for their influence on psychiatry. First, some scholars point to this moment as one of increasing neoliberalism, a political and economic theory that "proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade" (Harvey, 2005, p. 2). This shift became most evident in the 1980's, when Margaret Thatcher and Ronald Reagan deregulated and privatized formerly public services such as industry and agriculture in the U.K. and U.S., establishing structures and then providing minimal economic support afterwards (Harvey, 2005). By siphoning all ideals of influence and interaction into the market, the political and economic decisions entailed in neoliberalism shaped a society that functioned (and continues to) through "universal quantification and comparison" (Monbiot, 2016). These values were woven into the culture of the Global North and contributed to the emphasis on quantification as core to systems of diagnosis and treatment (Robbins, 2014).

Moreover, the adoption of neoliberalism also brought with it modes of cultural valuation based on one's ability to productively contribute to the market (Ehrenberg, 2010; Robbins, 2014). Health, some argue, came to be represented by individual productivity, and experiences of pain or other lapses in this ability were to be diagnosed and treated as illness (Ehrenberg, 2010; Robbins, 2014). Neoliberalism, therefore, has implications in creating a culture that both values a quantitative system of diagnosis and pathologizes unproductivity.

Neoliberalism and Death. Adding to understandings of neoliberalism's impact on grief in the U.S., historian Thomas Laqueur writes that the seemingly universal act of confronting death and caring for the dead speaks powerfully to the intersections of nature and culture in any particular context (Laqueur, 2015). Citing both historians and philosophers, Laqueur describes the dominant view of the 20th Century Global North as a time wherein death became taboo, subject to clinical

power and in “the regime of life” (Laqueur, 2015, p.14). Philosopher Jeffrey Bishop presents a narrative aligning with these dominant views, writing that the adoption of neoliberal political and economic systems across the larger culture, intertwined with priorities of quantification and efficiency, shaped understandings of and approaches to death (Bishop, 2011). Emphases on human productivity and technological efficiency, for example, influenced care for the dying in a seeming “return of the repression of death” in Global North medicine (Bishop, 2011, p.8). In caring for the dead, medical efforts were shaped into paths that diverged between care and cure, where death was fought with extreme interventions, as if avoidable, until it was deemed inevitable and accepted (Bishop, 2011). Moreover, the flows of power amid neoliberal culture and systems created new spaces for expertise regarding “the biological, the psychological, the sociological, and the spiritual” aspects of interacting with death, each of which enacted “total(izing) care” (Bishop, 2011, p.26). According to these narratives, rituals related to death were made private and discourse of death was wholly silenced (Laqueur, 2015).

Though this is the dominant narrative about a neoliberal 20th Century culture, Laqueur encourages a nuanced resistance to these discourses (Laqueur, 2015). He cites examples of death and remembrance that saturate modern life in the Global North, from war monuments to protest memorials (Laqueur, 2015). Neoliberalism created a culture that not only valued productivity and/in life, but that prioritized efficiency and independence, emphasizing universal comparison and ‘right’ ways to perform and produce (Monbiot, 2016). Reflecting this, technologies of cure and care produced not only mechanisms of fighting death, but new forms of decision making, which Bishop, invoking Agamben via Kaufman, argues led to the identification of “bare life,” or bodies deemed disposable (Bishop, 2011, p.11; Agamben, 1998). These decisions constructed hierarchies of value, deeming some life savable and, I argue, grievable. Therefore, in the cultural adoption of neoliberalism, death was not tabooed, nor mourning wholly shunned: certain deaths were merited as mournable while others were silenced, and certain modes of expressing grief deemed appropriate while others discursively disappeared (Laqueur, 2015). As will be discussed more later, the values, norms, and lives of socio-economically privileged, culturally powerful, white communities were those deemed valuable in the U.S. (Gaines, 1992). In sum, though varying, these literatures suggest that the

rise of neoliberal economic and political mechanisms contributed to the reinterpretation of health through the lens of individual productivity, to technological intervention against death for only some lives, and to the valuing of only some expressions of grief.

Pharmaceutical Influences. Conceptualizations of health and medicine in this era were shaped not only by larger cultural priorities, but also by institutional pressures (Horwitz, 2021). Even as diagnosis in psychiatry became one “of the book” at the demand of insurance and pharmaceutical systems, the contents and priorities of the book were also influenced by these systems (Whooley, 2019, p.164; Horwitz, 2021; Dumit, 2012). Anthropologist Joseph Dumit outlines three intertwining changes that occurred as pharmaceutical and medical institutions were reshaped: public health interventions were reoriented toward risks, rather than evidence, of illness, “smaller and smaller health risks” became the objects of treatment, and pharmaceutical companies grew in size and power (Dumit, 2012, p.6). As a result of these institutional decisions, risk was conflated with illness, illnesses were increasingly conceptualized as chronic, and ‘health’ came to be seen as inaccessible or myth (Dumit, 2012). Dumit argues that pharmaceutical companies played an important role in both medicalization and pathologization of human experiences in funding research, and thus shaping what questions about illness experience and drug efficacy/chronicity were (and are) able to be asked, and deciding (with profit in mind) what degree of symptom experience merits treatment (Dumit, 2012).

Scholar of rhetoric S. Scott Graham builds on these arguments with attunement to pain experiences, writing that pharmaceutical companies, in “medicaliz[ing] discomfort,” “subsequently invent[ed] diseases” by seeking profit in what would formerly have been accepted as normal (Graham, 2011, p.167). As early as the 1930’s, pharmaceutical medications were developed to relieve pain (Tousignant, 2014, p.119). Scholar Sheena Culley argues that these first pharmaceuticals targeting pain were marketed in such a way that suggested they might address both emotional and physical experiences – for instance, with images of treatment prioritizing “cheer” and “relax[ation]” (Culley, 2014, p.140). Culley argues that the 1960’s removal of such language and imagery from advertisements of physical pain medications was a direct result of the establishment of ‘depression’ as a medical classification and the corresponding rapid increase in psychopharmaceutical products

targeting (the suddenly “chemical condition” of) depression (Culley, 2014, p.145). Antidepressants, some argue, were produced to “sell” the idea that emotional pain is an illness to be treated by chemical means (Graham, 2011, p.169; Shorter, 1997; Stegenga, 2018; Dumit, 2012). Intertwined with the development and advertising of these technologies of treatment, Science and Technology Scholar Noemi Tousignant narrates, was the necessary creation of tools by which their efficacy could be established: quantitative measures for pain (Tousignant, 2014). I argue that these measures, this process of articulating and quantifying the until-then-incommensurable experience of pain, must not be overlooked as inevitable or as byproduct of technological advances, but that the process should be examined as dynamic technology of power and transformation in itself.

While narratives of causation diverge, and the operationalization of psychiatry/grief is likely due to an intertwining of these factors of seductive quantification, neoliberalism, and pharmaceutical development in addition to many others, the common theme of these literature must be noted: medicalization, whether of pain or of the psychiatric field itself, was influenced greatly by the cultural priorities of the moment, and it played a significant part in motivating the shift to operational models.

Implications of Operationalization

Sociologists Wendy Espeland and Mitchell Stevens claim that commensuration has become so ubiquitous in Global North cultures as to make invisible the assumptions required for it (Espeland & Stevens, 1998, p.315). One such assumption is the very claim that “social phenomena can be measured” (Espeland & Stevens, 1998, p.315). They write:

“When we assume the unity conferred by numbers, when the homogeneity among things appears to be a property of the object rather than something produced by quantification, then we imagine we are simply counting or measuring something rather than commensurating disparate entities.” (Espeland & Stevens, 1998, p.316-317).

In a manner that echoes the wielding of the clinical gaze by medical expertise, numerical data is not merely appealing – it often accepted as objective and nonpolitical (Merry, 2016; Espeland & Stevens, 1998). This “aura of objective truth and scientific authority” and the accompanying elision of “the extensive interpretive work that goes into [a measure’s or a statistic’s] construction” (Espeland & Stevens, p.1) is a significant manifestation of overlooked power (Merry, 2016; Espeland & Stevens, 1998).

Moreover, some philosophers argue that commensuration has the potential to be impactful not only in the power wielded in forming measures, but also in the relations and transformations that the measures produce (Merry, 2016, Espeland & Stevens, 1998, Hacking, 1995). Indicators and measures create truths by applying specific epistemologies, and within them the assumptions and motivations of those who hold power, thus reducing complex social phenomena into discrete and controllable categories (Merry, 2016). These indicators, measures, and categories, deemed objective or true because of the seduction of quantification, become the basis for further explorations, acting through what Merry terms “data inertia” (p.7) to compound reductionism and decontextualization in “creat[ing] new categories of meaning that shape the way we experience the world” (Merry, 2016, p.27).

Similarly, Espeland and Stevens use Foucauldian theories to discuss commensuration’s “constitutive power,” (Espeland & Stevens, 1998, p.331), wherein classifications are naturalized and individuals conform to them as a result of self-governance produced by the measures and categorizations themselves (Foucault, 1987). In other words, this inertial data makes real categories of ‘human kinds,’ through biopower, wherein individuals who are classified a certain way both measure themselves and increasingly perform according to the norms of that constructed category (Hacking, 1995; Foucault, 1987). Hacking introduces the concept of looping, or dynamic nominalism, wherein “people of a [human] kind behave differently and so are different,” causing the kind itself to change in response (Hacking, 1995, p.369).

It is, for these reasons, necessary that we not see commensuration as merely scientific method or the product of medicalization, but rather that we intentionally examine how and by what cultural powers a social phenomenon becomes quantifiable, what aspects of that phenomenon are deemed un/important in this process, and what implications may exist for the inertial reproductions of this construction (Merry, 2016; Espeland & Stevens, 1998).

Operationalizing (Medicalized) Grief

Having established the motivations by which operationalization entered the field of psychiatry and the conceptual implications of this change, this section will explore the discourse around

operationalization's practical integration. I will present a snapshot of the literature on the efficacy and limitations of measures. I hope to draw attention not only to the important benefits and critiques being named, but also the silences in the arguments, particularly that which Espeland, Stevens, and Merry point out: the seeming acceptance of operationalization as inevitable or as the linear product of medicalization (Espeland & Stevens, 1998; Merry, 2016).

Arguments for Operationalizing Grief (via related diagnoses)

As suggested in the brief narrative of psychiatry's shift to operationalized models in the 1980's, modern cultural reality dictates that qualitative accounts are rarely considered in examinations of grief; the psy-disciplines rely primarily on quantitative measures for 'empirical' knowledge production (Hacking, 1990; Horwitz & Wakefield, 2007; Granek, 2010). Granek writes that there was an "explosion" of measures for grief in the last decades of the 20th Century "indicative of the scientific and quantitative ethos of psychology at the time" (Granek, 2010, p.63). I will examine here a few of the benefits of operationalizing both grief and related mood disorders. Note that the grief described in these discussions is an already-medicalized one, having been recently rendered by the work of Deutsch, Lindemann, and others into the clinical realms of diagnosis and treatment.

Tools for Professionals. First, scholars in the psy-disciplines present practical and nosological advantages of operationalization. For instance, clinical professor of psychiatry Ronald Pies argues against models of diagnosis that take into account contextual information, and for operationalized scales as were first constructed in DSM-III (Pies, 2013). It must be noted that Pies' work represents an understanding of grief as existing in a binary, with some expressions 'normal' and others 'pathological,' and that he believes pathological manifestations of grief should be – and are – clearly defined in discrete diagnoses (Pies, 2013). Pies writes that recognition of a pathological state of grief is dependent exclusively on the crossing of "a certain threshold of suffering, impairment, and incapacity," and that the causes of or contexts in which a behavior arises are of no importance (Pies, 2013, p.287). He also argues that a patient's explanation of their own experiences may be "misleading," "incomplete," or not "reliable," and that only physicians can understand the true causes of a patient's behavioral or physiological experience (Pies, 2013, p.289). Compounding this, quantitative measurement allows for efficient representation and comparison of complex and

“elusive” ideas (Espeland & Stevens, 1998, p.316). Therefore, to some, measures are important tools by which an expert can systematically understand complicated experiences (Pies, 2013; Espeland & Stevens, 1998).

Furthermore, focusing on grief, Pies emphasizes the role of experts in disseminating measures, writing that patients may misattribute their experiences to a recent loss and neglect other causes, such as underlying pathology (Pies, 2013). He justly names the severity of major depression, the pain of ‘normal’ grief, and the necessity of treating pathological experiences, and he argues that ‘normal’ grief and major depression are easily separable in operationalized diagnosis (Pies, 2013). Many psychologists present arguments that align with these ideas, describing scales as beneficial, if not necessary, because of the significant psychological and physical health issues associated with grief and major depression (Arshad & Muazzam, 2016; Clark et al., 2005-2006). One group of scholars proposes that a measure for grief severity may notify a physician of experiences of loss in the patient’s life, even allowing the “doctor [to] count the actual number of losses” (Clark et al., 2005-2006, p.191). Moreover, measurements for emotional pain and pathology have been disseminated in broad contexts, Horwitz and Wakefield write, on the basis of discovering unacknowledged, and thus untreated, illness (Horwitz & Wakefield, 2007). Such dissemination can serve noble and impactful ends, including creating epidemiological statistics and shaping targeted treatment advertisements and initiatives to ensure that some seek and receive needed aid (Horwitz & Wakefield, 2007).

Grief scales thus have important potential as tools of communication between individuals and clinical experts (Pies, 2013). They also have, in some cases, diagnostic weight, and are able to open doors to important institutional facets of care and funding (Bandini, 2015).

Tools for Patients. Anthropologist Emily Martin, in exploring bipolar disorder, builds on these ideas, discussing the dissemination of scales as allowing individuals not only to be better understood by experts, but also to better understand their own mood experiences (Martin, 2007, p.178). Where some might see evidence of Foucauldian self-discipline, the internalization of external normalization and standards (Foucault, 1995), Martin sees benefit: “When many people fill out the same charts or register their moods on a numerical scale, they make their distinct experiences comparable... [and these scales] encourage people to manage their psychological states rationally so

they can work productively” (Martin, 2007, pp.178-179). The very scales which claim emotional experiences as the object of clinical expertise, Martin might argue, grant the power and control of “governing ... subjectivity” to “patients” themselves (Martin, 2007, p.179). It should be noted that these benefits of operationalization are priorities of the Global North’s culture, rooted in the need for rationality and control over uncertainty (Espeland & Stevens, 1998; Hacking, 1990; Granek, 2010; Gravesen & Birkelund, 2021; Merry, 2016).

Critiques of Operationalization and Medicalization

While it might be true that implementing measures for grief allows clinicians to gain a better understanding of aspects of their patient’s losses, researchers to shape large-scale interventions, or patients to feel more control over their experiences, many scholars argue that measurements are inadequate for fully representing grief (Masse et al., 2000; Horwitz & Wakefield, 2012). This section will explore key limitations that result from the logistical necessities of scale construction, particularly as they intertwine with the process of medicalization.

Deculturing Grief. First, even as scales are powerful in making complex concepts like grief “simple” and “accessible” (Merry, 2016, p.1), a primary weakness is the loss of notions of meaning, cultural idioms, and personal understandings of the grief process (Masse et al., 2000; Merry, 2016). Psychologist Joanneliese de Lucas Freitas writes that measures create a disconnect between the specificity of grief “understood in the context of experience and meaning” and that of grief understood “as phenomena” (Freitas, 2013, p.4). Affirming these notions, in describing the construction of both qualitative and quantitative examinations of “psychological distress,” one researcher concludes that “the quest for meaning and the quest for measurement are incommensurable research objectives” (Masse, 2000, p.411).

Some authors have discussed this challenge of decontextualization at work among cultural norms and expectations around grief (Granek & Peleg-Sagy, 2015; Rosenblatt, 2017). In 2017, professor of psychology Paul Rosenblatt published a review of his own extensive work on grief in different cultural and historical contexts, arguing that there is not only significant variance within an individual’s grief experience (i.e., “cycl[ing]” of grief in the lifetime after a loss), but also “that there are strong cultural differences in how people grieve” (Rosenblatt, 2017, p.617). Rosenblatt speaks

about the different “requirements of mourning” across cultures, ranging from ceremonies to time periods wherein individuals are not expected to perform ‘normally,’ and writes that this evidences both the universality and the sociocultural specificity of grief experiences (Rosenblatt, 2017, p.617-8). Death, loss, and grief are conceptualized and expressed differently across contexts, and researchers in many disciplines do not take this into account when articulating grief as a universal experience that can be operationalized (Rosenblatt, 2017).

Decontextualizing Grief. Building on this, psychiatric scholar Peter Rabins writes that grief appears in many contexts and in response to many ‘types’ of losses, such that expression and understanding can vary widely (Rabins, 2019). Leeat Granek and Tal Peleg-Sagy further complicate conceptualizations of grief by acknowledging that differences in socioeconomic status, gender, and education influence expression of grief (Granek & Peleg-Sagy, 2015, p.605).

Researchers have responded to some of these critiques by developing measures for grief that are specific to causes of death or ‘types’ of loss – for instance, grief experienced by cancer patients, by caregivers of individuals diagnosed with dementia, or in the context of general medicine (Arshad & Muazzam, 2016; Cheng, Ma, & Lam, 2019; Clark et al., 2005-2006; Rabins et al., 2019). While some researchers have found these categorical specifications helpful, others argue that they bring about new complications (Rabins, 2019; Cheng, Ma, & Lam, 2019). For example, a significant challenge is separating aspects of grief from those of other intertwined experiences associated with loss and difficult life circumstances (Rabins et al., 2019). Scholars of psychology and geriatrics Cheng, Ma, and Lam discuss the difficulty of measuring the grief among caregivers because many experience exhaustion, unhappiness, anger, isolation, or anhedonia associated with the burden of caregiving itself (Cheng, Ma, & Lam, 2019, p.1100; Rabins et al., 2019). Additionally, operational definitions of grief have been called into question regarding death by race-based violence, for instance, wherein anger and hopelessness surrounding the murder are intertwined with grief over the loss of life (Rosenblatt, 2017). Relatedly, there is little room in current psy-discipline conceptualizations of grief for ongoing and often denied inequities, such as systemic racism and assimilation (Eng & Han, 2019). Some authors thus argue that, if operationalized scales purport to measure grief as an isolated response, it is necessary that they untangle the complicated emotional and physical experiences associated with

hardships and examine only those which are seen as ‘grief’ (Rabins et al., 2019; Cheng, Ma, & Lam, 2019). The literature is relatively silent on the plausibility of this untangling.

These arguments thus imply that operationalized measures for grief, in seeking to define and evaluate a singular grief, are inherently limited because of cultural and contextual variation.

Regrounding in the conceptual implications discussed above, it is important to remember that these limitations are rarely given space for consideration because of the seductiveness and presumed objectivity of quantification (Merry, 2016).

Coloniality in Research. Psychiatrist Warren Kinghorn writes that the shift towards medicalization through the language of pathologies was at the root of the field’s rationalization of its own existence: “psychiatry attains and asserts its power and influence by colonizing particular domains of human life and culture as ‘mental illnesses’ and then by offering itself as the appropriate authority for their ‘treatment’” (Kinghorn, 2013, p.48). In recognizing quantitative operationalization as the process by which definitions of pathology are disseminated into a culture that accepts only narrow expressions of grief, it becomes clear that measures have the potential to institute coloniality of being and behaving by pathologizing that which does not align with the white ideal.

Building on this within grief studies, Granek and Peleg-Sagy argue that definitions of ‘normal’ grief have, like many definitions of ‘normal’ in Global North psy-disciplines, been constructed around the expectations for and experiences of educated and upper-class individuals who identify as White men (Granek & Peleg-Sagy, 2015; Gaines, 1992). This behavioral imperialism is exacerbated in that, not only is there is a dearth of racially/culturally representative studies of grief, but grief research published in the Global North conceals its own lack of representative diversity: psychological studies frequently neglect to report the “sociodemographic information including socioeconomic status, education, and ethnicity/race” of their subjects at all (Granek & Peleg-Sagy, 2015).

If we take seriously previous arguments on the inherent cross-cultural and contextual differences in grief norms, this research trend can only be seen as intentionally presenting undeniably narrow articulations of grief as ‘objective’ (Rosenblatt, 2017; Rabins et al., 2019). Coloniality is thus at work in psy-discipline treatments that advocate specific culturally-determined behaviors as ‘health’ and, in doing so, force the Other/the colonized subject to “thoroughly fit into a social environment of

the colonial type” (Fanon, 2004, p.182). Because psychological research forms the basis for operationalized definitions and measures of grief, including measures that delineate pathological from ‘normal’ grief, the projection of white experience as universal must be acknowledged and reckoned with if measures for grief are to be useful, or even if they are to be innocuous.

In sum, this section has included arguments for and against the use of measures to quantify grief experiences, revealing important uses and limitations of operationalization, even as suggestions for improvement (e.g., by specification) also reveal the ways measures are accepted, unquestioned, as the tools of the psy-disciplines. The stakes of these acceptances are significant because, in articulating specific causes, experiences, and expressions as ‘grief’ and pathologizing all else, individuals who mourn unacknowledged losses/inequities and who grieve in ways beyond the white norm are treated as ill.

Grief in the Present

It is important to ground the timeframe of focus in this study in not only the cultures and decisions leading up to it, but also the changes that it resulted in. This section will give an abbreviated overview of the transformations of grief since 1970, including discussion of notable timepoints toward the current conceptualizations within the psy-disciplines. I will also briefly discuss a few non-hegemonic conceptualizations of grief that arose in response to its operationalization and medicalization. The purpose of this section is therefore to illustrate both that the period of focus in this project is a significant one, in that it set the conditions of possibility for the present (Garland, 2014), and also that the method of the psy-disciplines are not the only ones, even as they may assert dominance.

Since DSM-III

After the revolutionary publication of DSM-III in 1980, a revised version (DSM-III-R) was published in 1987 and the fourth edition (DSM-IV) in 1994 (Horwitz, 2021). Horwitz argues that the most substantial changes having to do with these publications were not in content, but in “their emergence as important cultural documents” (Horwitz, 2021, p.88). Language of diagnoses increasingly entered the public discourse, informing how individuals perceived themselves and others,

and edits to the DSM were of great popular interest for the first time (Horwitz, 2021). This heightened attention took hold also in mental-health related epidemiological research, advocacy groups, and political discourse, creating statistics and efforts that invigorated the power of psychiatry by reaffirming Freud's claims that all may be susceptible to mental illness (Horwitz, 2021).

Two key portions of the DSM are important to track in examining grief: the diagnosis of major depression and direct mentions of grief. The DSM-III contained a widened definition for major depressive disorder such that it included "almost any conceivable set of symptoms, including the market basket of non-melancholia" (Shorter, 2008, pp.151-152). Importantly, this diagnosis included a 'bereavement exclusion,' meaning no individual could be diagnosed with major depression if their symptoms aligned with a recent loss (Bandini, 2015). DSM-III also included direct mention of normal and pathological reactions to loss in a separate note, stating that "severe expression of grief" may be a sign of underlying major depression (Bandini, 2015, p.348). The DSM-IV further broadened these criteria, positing that bereaved individuals could be diagnosed with major depression if they continued to experience symptoms two months after the loss (Bandini, 2015). Horwitz narrates the uptake of this cultural emphasis and broadening inclusion (despite lack of significant change in diagnostic criteria), writing that prevalence of the major depression diagnosis among Americans increased more than 300% between 1987 and 1997, and "among office-based physicians, depression accounted for 42% of mental health diagnoses from 2007 to 2010" (Horwitz, 2021, p.102). While these increases are likely due to a combination of cultural awareness of diagnoses and medications, cultural pathologizing of pain, and emotional pain related to both grief- and non-grief-factors, they are important to note in the trajectory of grief (Bandini, 2015; Horwitz, 2021).

The DSM-5, published in 2013, removed the bereavement exclusion from the diagnostic criteria for major depression, meaning anyone who experienced the (continually broad, as Shorter argued) symptoms for at least two weeks could receive the diagnosis, regardless of external cause (Bandini, 2015; Shorter, 2008). This removal was rationalized by studies arguing that bereavement- and non-bereavement related depression were similar, that bereavement related depression may be more severe than non-bereavement, that the change would align with ICD-10 criteria, and that clinical discernment should play a role in distinguishing pathological and non-pathological bereavement

(Bandini, 2015). For instance, Ronald Pies writes that grief and depression are “distinct constructs,” and “bereavement does not immunize the patient against major depression, and often precipitates it” (Pies, 2014, p.20).

Moreover, in addition to ‘qualifying’ for the major depression diagnosis two weeks after a loss, DSM-5 and its revisions have continued with mentions of grief pathologies, research and discussion on which shifted most drastically in late 2021 (Kecmanovic, 2021). Ahead of the publication of the revised manual (DSM-5-TR), Prolonged Grief Disorder was added as an official diagnosis (Kecmanovic, 2021). Authors note that this construct, referred to as prolonged and written to apply to individuals experiencing grief after one year, aligns closely with (and perhaps serves as proxy for) another, complicated grief, which was introduced in the corpus of this project (Kecmanovic, 2021). Moreover, throughout discussion of the diagnosis, there is emphasis on its distinctness from major depression – and thus on the reality of a discrete category of pathological grief experiences (Kecmanovic, 2021; Pies, 2014). A subset of psy-discipline research on prolonged and complicated grief has blossomed in the past decade, and will likely only continue to increase now that the category holds heightened status. A newly developed treatment method that combines targeted behavioral therapies and medications as needed has been presented alongside the diagnosis (Kecmanovic, 2021).

In addition to research into treatments for pathological grief, a number of novel approaches in grief research are burgeoning, and they speak to significant refocuses in conceptualizations of grief. While there are many ongoing areas of analysis, from functional neuroanatomy to intervention development, I will focus here on only one of these approaches. A recently developed field of investigation, “network analysis,” conceptualizes “mental disorders as networks of mutually reinforcing nodes (i.e., symptoms)” (Robinaugh, Millner, & McNally, 2016, p.747). This method systematically deconstructs pathologies into their symptom components and investigates correlations in the severity of each ‘node’ in an effort to predict outcomes and develop treatment for particularly powerful symptoms in the ‘network’ (Robinaugh et al., 2016; Borsboom & Cramer, 2013). In other words, these methods construct webs of decontextualized symptoms, map the strength of connectivity between each symptom-node, evaluate certain symptoms as more central to overall experience, and

target these symptoms directly in the hopes that links in the network will weaken the overall severity of the grief experience (Robinaugh et al., 2016).

The process of decontextualization in these approaches is not incidental, and is even presented as the strength of the approach (Borsboom & Cramer, 2013; Maccallum et al., 2021). As one article states, “network approaches naturally explain the limited success of traditional research strategies, which are typically based on the idea that symptoms are manifestations of some common underlying factor” (Borsboom & Cramer, 2013, p.91). These thoughts have shaped conceptualizations of the new Prolonged Grief Disorder, such that it is, by some researchers, not approached as a reaction to loss, but as a set of symptoms which “directly cause and reinforce each other” (Maccallum et al., 2021, p.2). Decontextualization of grief into its symptom components is startling in that it suggests an abandonment of the very definition of grief – as an experience resulting from loss – and thus deprives approaches to diagnosis and care from access to conceptualizations rooted in the realities of loss. This mode of research, while just one of many in the psy-disciplines, speaks powerfully to modern conceptualizations of grief as a measurable medical object, to be studied and treated according only to its operationalized dimensions.

In addition to these grief-specific changes, the psy-disciplines have also only strengthened their knowledge-power reign on mental illness in both clinical spaces and the general populous. As Horwitz describes, DSM language and codes have become the common guide for all of the psy-disciplines, as well as for insurance and pharmaceutical institutions (Horwitz, 2021). Further, the DSM-V-TR was officially published in March 2022, bringing for the first time an official diagnosis for pathological grief into a culture ready, not to sit in silence or remember mourning rituals, but to map and correct symptoms (Pavia, 2022). And, published into this world of citizen-consumers ever-eager to learn about our health, the DSM-TR-V had made The Wall Street Journal’s bestseller list by May 2022 (Pavia, 2022). To what extent have we internalized the clinical gaze?

In sum, in the decades since the publication of DSM-III and the timeframe of focus here, psychiatry has only continued the trends of medicalization and decontextualizing operationalization in ways that radically reconfigure individuals’ relations with their selves and their grief.

Reactions and Exceptions

Even as I hope to illustrate the power that the psy-disciplines have over knowledge-creation about – and diagnosis and treatment of – grief, it is important to acknowledge that there are pockets within U.S. culture that intentionally resist the psy-discipline’s hegemony. As will be discussed later, many community-oriented approaches to grief (e.g., support groups) have been inculcated into the psy-disciplines by requiring that their facilitators and methods be trained/developed within the science. For that reason, I will only discuss approaches here that have arisen as intentional confrontations of psy-discipline conceptualizations of and approaches to grief. I will briefly discuss two examples, which I hope will be illustrative, even as I know that there are many others.

Public Feelings. First, within academic circles, one important instance of a community formed around intentionally creating in opposition to the cultural pathologizing of emotional pain is the national Public Feelings Project and associated Feel Tank in Chicago (Cvetkovich, 2012; Berlant, 2011). This was a group of scholars (many within queer theory, including Ann Cvetkovich, Lauren Berlant, Anne Pellegrini, Kathleen Stewart, and Jose Munoz, among others) from whose work in community have stemmed multiple powerful works, theoretical and reflective (Cvetkovich, 2012; Berlant, 2011). Cvetkovich summarized the collective’s orientation toward the pathologization of emotional expression: “a political analysis of depression might advocate revolution and regime change over pills, but in the world of Public Feelings there are no magic bullet solutions, whether medical or political, just the slow steady work of resilient survival, utopian dreaming, and other affective tools for transformation” (Cvetkovich, 2012, p.2). The group gathered and worked, therefore, to “depathologize negative feelings,” to recognize feelings’ rootedness in political and cultural moments and resist their medicalization (Cvetkovich, 2012, p.2). They set forth an acceptance of negative emotions, including grief, even as they sought to recognize their intertwinement with hope and action (Cvetkovich, 2012).

In *Cruel Optimism*, Lauren Berlant describes impasses that saturate neoliberal society, narrating hope as an enforced crippling in spaces where upward mobility and justice are always out of reach (Berlant, 2011). The necessitating of optimism that accompanies the pathologization of pain is, in Berlant’s rendering, a technology of neoliberal culture, a crisis unnamed in that it has been made

ordinary (Berlant, 2011). In *Depression: A Public Feeling*, Cvetkovich urges – and, in writing, enacts – not only critical examinations of pathologies in a time of neoliberalism and political injustice, but also intentional personal engagements with her own experiences (Cvetkovich, 2012). As a whole, the group has enacted and theorized a range of methods, from activism to thinking-in-community, spiritual and artistic practices to writing-about and writing-as expression (Cvetkovich, 2012; Berlant, 2011). These choices reveal an acceptance of grief that embraces its articulations beyond those created within the psy-disciplines, its rootedness in reality, and its necessarily communal and ongoing experiencing – and, in each of these, an enactment of grieving that resists operationalization and medicalization.

Grieving Communities. A second example of a community engaging in intentional confrontation of the medicalization of grief is the National Alliance for Children’s Grief. The Alliance is a network of non-profit organizations that provide advocacy, presence, and community support for local grieving children, families, and groups (“About the NACG,” 2021). Outward-facing work frequently takes the form of awareness events and activities in recently bereaved communities (e.g., classrooms, workplaces), confronting cultural taboos of mourning by fostering conversation about loss and grief and encouraging public remembrance.

Further, an example daily program at a center for grieving children² involves peer support groups, where community volunteers lead children in crafts, dances, conversations, and games. The goal in these spaces is not to articulate grief, or even to foster ‘grief work’ in any intentional process, but rather to create spaces of comfort and normalcy. Children are encouraged to express sadness as well as joy, anger, hope, or any other feeling – to use words (particularly words beyond those of symptom and diagnosis), or to use play, creation, or movement in lieu of words. Children and families are welcomed into groups any time after they experience a loss, and are encouraged to stay until they feel that they no longer need groups – and to return if they ever feel need again. In ‘facilitating’ groups, the main roles of volunteers are to ensure safety and to foster comfort. In groups

² I had the opportunity to work at one of these organizations, the Center for Grieving Children in Portland, ME, for 12 months. Even as the information in this section comes directly from this experience (and thus no further citations), I am hopeful that the lessons I learned from expressive-arts coworkers, grieving kindergarteners, and refugee/asylee middle schoolers seep into the larger foundations of this paper.

and teachings at centers for grieving children, staff and volunteers name grief as expected, even as they emphasize that grief does not take expected forms, features, or paths. Mourning is welcomed by presence, grief is not examined as medical, and expression is encouraged in creation and activity as much as – if not more than – in words.

From theorizing with affects to expressing with crayons, I hope that these two examples of spaces where grief is practiced in opposition to the medicalized norm might illustrate both 1) that the psy-discipline conceptualization is not the only ‘grief’ and 2) that non-psy spaces powerfully foster expression that leans into the reality of grief’s in/articulations beyond the medical (much less its inability to be counted).

Position and Significance of the Present Research

This review has presented the paralleling narratives of grief’s medicalization and operationalization, as well as glimpses into modern spaces of grief within and beyond the psy-disciplines. There is an abundance of literature detailing the histories of grief’s medicalization, some of which includes the incorporation, advantages, and disadvantages of its operationalization. However, these processes are presented as linear in histories of psychiatry: once grief was taken as an object of medical examination, symptoms-based definitions were accepted and measurements for grief ‘progressed,’ as if inevitable. Individuals processing incomprehensible losses became subjects experiencing grief, who in turn became enumerations of symptom severity: human griever, because of operationalization, are “stripped of agency; they ‘endure’ but have no initiative, they are sites with measurable attributes but do not ‘participate’ in or actively produce the events of interest” (Masse et al., 2000, p.417; citing Mishler, 1996, p.79).

While Granek grounds her narration of the speedy development and use of measures in the medicalization of grief (Granek, 2010), researchers have yet to explore the possibility of a dynamic interaction between these two processes. It is necessary to bring awareness of the constitutive power of measure-creation into a critical analysis of grief-related discourse within the psy-disciplines in order to shed light on the twisting-together of operationalization and medicalization in the clinic and in the body of the grieving human. This literature review thus informs key questions – including

those urged by Merry, Espeland, Stevens, and others – that guide this research: (How) Do the psy-disciplines rationalize the very possibility of measuring grief: what do the explanations, tautologies, and silences show us? How can a dynamic model of power, knowledge, and expertise inform our understanding of the historical and current conceptualizations of grief? How do medicalization and operationalization intertwine and interact to reify, redefine, and pathologize grief?

My aim in the current research is to push into these questions and to examine the complications neglected in a linear narrative of operationalization as the product of medicalization. Humans must not be seen as objects, but as existing within a dynamic network of these ongoing processes of quantification, expertise-formation, definition, and re-definition. This examination of the interactions between the operationalization and the medicalization of grief, though small, has the potential to elucidate understandings of power within discourses of expertise – understandings which, I argue, are necessary if we are to effectively challenge the reductive, reifying, and injurious medicalization of grief.

Methods

The main goal of this study was to examine knowledge production around definitions and conceptualizations of grief within the psy-disciplines, focusing on the processes and implications of operationalization. The primary method employed was critical discourse analysis, with data consisting of studies published in American psy-discipline journals between 1975 and 1995 that focused on grief. This analysis was conducted through the method of grounded theory, wherein networks of knowledge were analyzed iteratively based on themes (organized into a codebook) that arose from close comparison between articles and journals. Critical discourse analysis via grounded theory was selected in order to gain a deeper understanding of both 1) linguistic trends in publication content and 2) power relations as signified in and enacted through language, thus allowing for a more whole understanding of the modern conceptualization of grief.

I must acknowledge that this project uses the methods of the social/sciences in an effort to better understand and critique the social/sciences: in using these shared methods and tools, I am not

perceiving and acting from beyond modern frameworks of analysis and understandings of authority and credibility (Harding, 1986). Histories of science are autobiographies of institutions, and are for this reason “selective reports” (Harding, 1986, p.208), limited by selection of and access to resources and by “the inadequate conceptual schemes of the social sciences more generally” (Harding, 1986, p.209). As such, this analysis is not written anachronistically, nor from an isolated position (Harding, 1986, p.248), but from an embedded position in and using methods deemed “good” by the same societal and cultural values that shape conceptualizations of grief (Harding, 2015, p.27).

Data Collection

The only key term search criteria was the presence of “grief” in the article title. This decision was made to include both articles that pertained directly to the development and validation of operationalized measures for grief and studies that made use of those measures or otherwise defined grief, thus allowing for a broader understanding of the contextualized conceptualizations of the term. This broad search criteria required additional manual article selection, which was done under the guiding questions of: 1) Does this article take ‘grief’ (defined as reaction to a loss) as its main object of study?, thus excluding studies of grief as a secondary factor in study of other experiences or pathologies; and, 2) Does this article represent or speak to the psy-disciplines – i.e., by experts in or using the methods of psychological/psychiatric research?

As discussed in the literature review, a key transformative era in the conceptualizations both of grief as pathological and of psychological experiences as measurable occurred in the decades surrounding 1980, particularly with the publication of DSM-III. In order to examine this transformation fully, the chronological bounds on article publication were set to 1975-1995, thus including articles published shortly before, during, and shortly after the key era. The latter years were included in order to glimpse the beginnings of the longer-term impacts of this moment. Additional manual exclusion was used to limit the data to articles that were originally published in this era, excluding republications of pre-1975 research.

The minimum criteria for journals of consideration were: fully accessible via Vanderbilt University libraries, primary publisher of original research (i.e., not review articles), peer-review, publication in/focus on the United States context, first publication before 1975, and regular publication throughout the 1975-1995 decades. Based on an original search through PsychInfo, three journals met these criteria and contained at least 10 articles published between 1975-1995 with “grief” in the title. These journals were *The American Journal of Psychiatry*, *The American Journal of Orthopsychiatry*, and *Omega: Journal of Death and Dying*. Inclusion of each was confirmed based on relative influence in the psy-disciplines.

The American Journal of Psychiatry, first published in 1844 as *The American Journal of Insanity*, is considered “the most widely read psychiatric journal in the world” (Kalin, 2022). It is the official journal of The American Psychiatric Association (APA, which notably also publishes the DSM), and contains peer-reviewed content relevant to psychiatry and other mental health professions (Kalin, 2022). *The American Journal of Orthopsychiatry* is published by the American Psychological Association and is a key journal of the Global Alliance for Behavioral Health and Social Justice (McLeigh & Spaulding, 2022). It was first published in 1930 and includes content most related to mental and behavioral healthcare – particularly public health and prevention, child development and family health, and care disparities (McLeigh & Spaulding, 2022).

Omega, while generally included under the psy-disciplines, falls into the discipline of thanatology, an interdisciplinary field that emerged in the 1950’s in the wake of WWII (Fonseca & Testoni, 2011-2012). Founded in 1970, *Omega* was the first journal to be created out of this movement (Fonseca & Testoni, 2011-2012), and it includes scholarly perspectives from “the fields of psychology, sociology, medicine, anthropology, law, education, history and literature” (“Omega,” 2022). Though *Omega* does not exclusively publish within the psy-disciplines, this journal was included for two reasons. First, Nikolas Rose argues that the psy-disciplines, in staking claims of expertise on the self, have shaped knowledge that has informed concepts about human behavior and regulation within many disciplines (Rose, 1998). In other words, content published about the behaviors and selves of humans – including about death, dying, and mourning – within non-psy-

disciplines can be seen as shaped by, if not one with, the psy-disciplines (Rose, 1998). Second, in noting increasing claims of exclusive expertise among the psy-disciplines in this time, articles from *Omega* were included in an effort to acknowledge the variety of perspectives forming the borders of psy-discipline discourse about ‘grief.’

Based on the initial search under these journal, date, and title criteria, 84 peer-reviewed articles resulted: American Journal of Psychiatry (AJP): 30, American Journal of Orthopsychiatry (AJO): 13, and Omega (O): 41. Of this initial list, 14 articles were excluded according to the aforementioned manual exclusion criteria. While journals were chosen based on U.S. focus, five articles included were published by authors from or including research conducted outside of the U.S. This was accounted for in analysis and these articles were included in an effort to understand the global influence of these discourses. The final data set included 70 articles (AJP 20, AJO 10, and O 40). A bibliography for the dataset is in Appendix 2.

Analysis

The primary method of analysis employed in this study was a critical discourse analysis (CDA), a form of discourse analysis (defined as study of “the uses of language,” Hodges, Kuper, & Reeves, 2008, pp.570) that pays particular attention to the relationship between language and power (Hodges, Kuper, & Reeves, 2008; Blommaert & Bulcaen, 2000; Le & Le, 2009, Baker et al., 2018). Linguistics scholar Paul Gee introduces the concept of language’s “situated meanings” as determined by the “cultural models,” or norms and standards in which words are contextualized (Gee, 1999, pp.80-81). Words are both constructed by and serve to construct contextual moments and realities (Gee, 1999, p.82), such that meaning, culture, material, and context weave together into “situated network[s]” of knowledge production (Gee, 1999, p.83). With these interactive processes in mind, discourse analysis is an examination of language as shaped by – and shaping – the situated network it lies within (Gee, 1999). This method was beneficial toward the aims of the present study because of its acknowledgement – and, indeed, prioritization – of the dynamic relationship between

conceptualizations of terms by expertise and societal re-conceptualizations of and responses to those terms (Hacking, 2007). Moreover, unlike the broader historico-cultural focus of the literature review, this method is attuned to dynamics of power and control as they are evident in details, including the construction and uses of a particular ‘grief,’ the changes and consistencies in motivations described, and the choices made linguistically and disciplinarily. This allows for a clearer understanding of the mechanisms of change by the possibilities presented and elided in textual decisions.

A method based on grounded theory was employed in the construction of a coding process for the critical discourse analysis. Under this method, networks of knowledge were analyzed iteratively with “granular analysis,” or close and repetitive comparison of small details within articles (O’Connor, Netting, & Thomas, 2008; Tavory & Timmermans, 2009, p.247). This allowed for patterns in the data to arise and to guide each step of the analysis (O’Connor, Netting, & Thomas, 2008; Strauss & Corbin, 1998).

After the sample was collected, I read the articles in an initial open coding process, pulling small excerpts of each article. I then closely compared these extracted sections and organized them into categories according to the main goals of the research and key themes and trends that arose in the reading process. Examples of categories constructed around excerpts that were question-led (deductive) include portions of text defining grief, describing the purpose for studying, measuring, or treating grief, and describing theories or models concerning the grief process. Examples of categories that stemmed from the data (inductive) include portions of text describing particular modes of death or objects of loss, references to cultural or disciplinary rationale for research, references to previous work of key authors, and references to depression as part of or as separate from the grief experience.

I closely examined the small excerpts of text collected under these categories in order to better grasp the trends present in the data. I then compared these categories with one another in a process of axial coding, structuring the categories (combining, separating, and nesting codes within one another) in such a way that formed a codebook. To test the usefulness of the codebook constructed in this axial coding step, I entered it into the qualitative analysis software Atlas.ti and coded articles (n=12, 17.1%) from each of the three journals at each chronological end of the dataset.

Using the codebook in this subset of the data allowed me to see gaps, overgeneralizations, or other functional errors and make edits to better ensure thorough and data-led analysis. These edits included restructuring, for instance to allow for a clearer differentiation between codes for content and mode of explanation. I also shifted the codebook to allow for acknowledgement of differences between medicalization, physiological definition, and pathologization. I added categories: time of loss as a factor of consideration, other grief phenomena (including anticipatory, disenfranchised, and mourning) as objects of analysis, and references to the meaning of ‘recovery.’ Finally, I shifted the meanings within categories, for instance expanding the code for references to ‘normality’ to also include those to universality or natural-ness, and expanding a code for ‘site of intervention’ to also include references to the mode of intervention or suggested methods of treatment.

The edited codebook, compiled and structured as guided by this iterative reading of the data, can be seen in Appendix 3. With this codebook, I recoded the subsample and coded each remaining article in the data in Atlas.ti. In order to ensure a consistent use of the codebook, I double-coded 34% (n=24) of the articles.

Once all of the articles were coded, and a portion double-coded, I continued the process of close comparison by analyzing the excerpts of all of the articles in each code. In order to allow for some comparisons between codes, to see overlap between codes, and to minimize decontextualization of the excerpts, I recombined some codes in this step of the analysis – for example, looking at all modes of definition (physiological, psychoanalytic, psychological, and other) together. I noted patterns and exceptions that arose in this process in a series of brief statements. For each code/set, I examined these brief statements, paying particular attention to trends that evidenced the role of measures and that displayed changes over time. To supplement this data, I completed brief content analyses on frequency-based variables, such as the definitions for normal and pathological grief, as well as on phrases that arose in the coding process. I completed these analyses using the digital humanities tools Voyant Tools and AntConc, text visualization and processing tools that provide data on word and phrase frequency, clustering, and consistency across a corpus. The findings of the discourse and content analyses can be seen in the results section.

Results and Analysis

The goal of this section is to summarize the trends of the nature and content of the articles present in the corpus. The research questions that guided analysis were: Between 1975 and 1995, how was grief defined and examined in psy-discipline research? What trends exist in the development of, use of, and arguments for using quantitative measures for grief? What power relations and changes can be seen in the (changing) priorities of this era?

This section will begin with a brief overview of the data, followed by the results of the analyses. The discourse analyses focused on six main areas of content: conceptualizing grief, conceptualizing pathological grief, grief-related concepts, studying grief, measuring grief, and contexts of grief research. Within these, supplementary content analyses were used to learn about trends within the definitions of normal and pathological grief and measurements for grief.

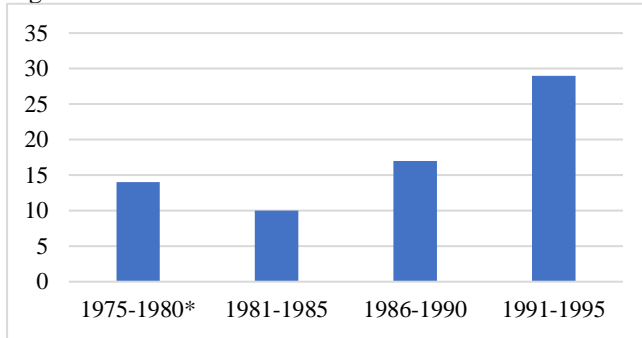
Publication Characteristics

In total, 70 articles were included in the corpus. A slight majority (n=40) of the articles were published in *Omega*, followed by *The American Journal of Psychiatry* (n=20), and *The American Journal of Orthopsychiatry* (n=10). The articles in the dataset represented multiple perspectives within the psy-disciplines, a large chronological range, and a variety of approaches to studying grief, as will be explored in the following sections.

Publication Details

This section gives an overview of the articles included in the corpus, including year and country of publication and information about authors. The number of articles about “grief” published in these three journals generally increased over the course of the 21-year span; Figure 1 illustrates this increase. Figure 2, in Appendix 1, shows the number of articles published by each journal each year.

Figure 1. Overall Publication Trends



Number of articles included in study by year published.

*note that the 21-year span is broken unevenly, with the 1975-1980 span including six, rather than five, years.

Five articles were published outside of the U.S. or included data collected among populations outside of the U.S. These articles were almost all published in/about the Global North (Germany, Australia (2), and Canada), except for one American resident writing about research conducted in Nigeria. Moreover, with the exception of two of these non-U.S. articles, which described bereavement customs and their effects on the grieving process among the communities that practice them, there was no significant difference in the conceptualization of ‘grief.’ For each code analyzed, the content of all five of the non-U.S. articles aligned within the patterns of the remainder of the data set. Moreover, one non-U.S.-based author (Stroebe) was cited in seven later (U.S.) sources.

The majority of articles were written by one author (n=37, 52.9%), with the maximum number of authors being nine. See Table 1 in Appendix 1 for details on number of authors. In general, the number of authors increased slightly over time, and there were no significant inter-journal trends. Moreover, there were a total of 118 authors represented in the dataset. Most authors (n=107) were only listed on one article, with 7 authors being listed on two articles, 3 on three, and 1 on four. Of the 11 authors to have multiple citations, 5 were published in both Omega and (one of) AJP or AJO. This affirms the alignment of Omega’s content with that of the more formerly psy-discipline journals. Moreover, one author, Zisook, was cited on three articles in AJP and two authors, Toedter and Lasker, were cited on (the same) three articles in AJO. Because there were only ten articles from AJO and twenty from AJP, and in an effort to not allow the trends specific to these research groups to overpower a reading of norms within each journal, analysis for trends between journals was de-

emphasized. The articles were taken as a more general group and analyzed primarily according to year of publication.

Genre and Methods

The articles included represented a wide range of modes of analysis and main aims. When categorized into seven main groups (Review of a book or article; Literature review; Investigative research; Developing a measure; Investigation and measure development; Intervention; and Proposing a theory/model), the most common category was Investigative research, followed by Reviews of books or articles and Proposing a theory/model. Figures 3 and 4, in Appendix 1, illustrate the trends in type of article published according to journal (Figure 3) and year of publication (Figure 4).

In terms of article content, the vast majority of articles used the methods/analysis of the psy-disciplines to examine, construct a measure for, or discuss and propose a theory relating to grief as an experience, most frequently among the bereaved. A few notable exceptions exist: Robinson (1978, AJP) argued that grief models can apply to the experiences of medical student spouses in the first year of (the spouse's) clinical experience; Engel (1980, Omega) and Irwin & Melbin-Helberg (1992, Omega) proposed models for teaching mental health professionals about treating grief; Atkinson (1982, Omega) and Carson, Warren, & Doty (1994, Omega) studied resources present to care for grief in school settings; and Wambach (1985, Omega) and Irving (1992, AJP), two theoretical outliers, examined the manner in which the grief process, as a social construct, is understood and wielded among various populations or institutional settings. Given the multidisciplinary nature of Omega, the presence of four education/resource-oriented studies is unsurprising. This inclusion is nonetheless notable in that it evidences a way in which institutions nominally outside of the psy-disciplines were implicated in or affected by the changing conceptualizations of grief within the psy-disciplines (Rose, 1998).

Additionally, it should be noted that 5 of the articles published in the American Journal of Orthopsychiatry (50%) had to do with perinatal or maternal loss, perhaps because of orthopsychiatry's focus on child and family-models. This trend affirms the decision to conduct comparative analyses only chronologically, and not between journals, in order to minimize author- and topic- influence.

Data Used

Figure 5 shows the type of data used in the corpus, organized chronologically. In this graph, qualitative data (yellow) includes case studies, interviews, and clinical experience. Quantitative data are all represented by shades of blue. The Texas Inventory of Grief (TIG) and Grief Experiences Inventory (GEI) were the most consistently used quantitative measures.

Figure 5. Type of Data

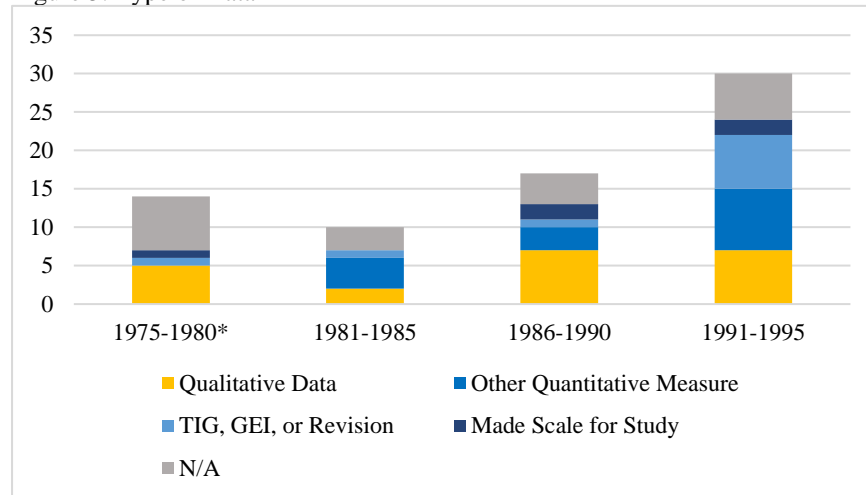


Figure 5 shows type of data used in each study, by year published. TIG, GEI, or Revision refers to the Texas Inventory for Grief (TIG), the Grief Experiences Inventory (GEI), or a revised version of one of these scales. The category Made Scale for Study refers to studies that developed a measure or questionnaire specific to their research question (measures only used in one context). Other Quantitative Measures is the grouping of all other scales used, including: the Inventory for Complicated Grief (ICG), the Affective Inventory, the Attitude Inventory, the Response to Loss Instrument, and a measure for bereavement-related depression called the Center for Epidemiological Studies-Depression (CES-D). The grouping N/A refers to studies that did not examine variables among subject pools, including book/article reviews, literature reviews, and discussions of theories or models.

*note that the 21-year span is broken unevenly, with the 1975-1980 span including six, rather than five, years.

When looking only at studies that examined variables among subjects, Figure 6 shows the relative proportion of studies that used qualitative data (yellow; case studies, interviews, and clinical experience) versus those that used quantitative data (blue; TIG, GEI, Other, and scales made for each study), separated among the same years. These graphs, and the related qualitative data, reveal a general upward trend in the use of quantitative data relative to qualitative. It must be noted that the proportion seen in 1981-1985 seems to be an outlier. One possible cause is the relatively low number of eligible studies published in this era.

Figure 6. Proportion of Quantitative vs. Qualitative Data Used

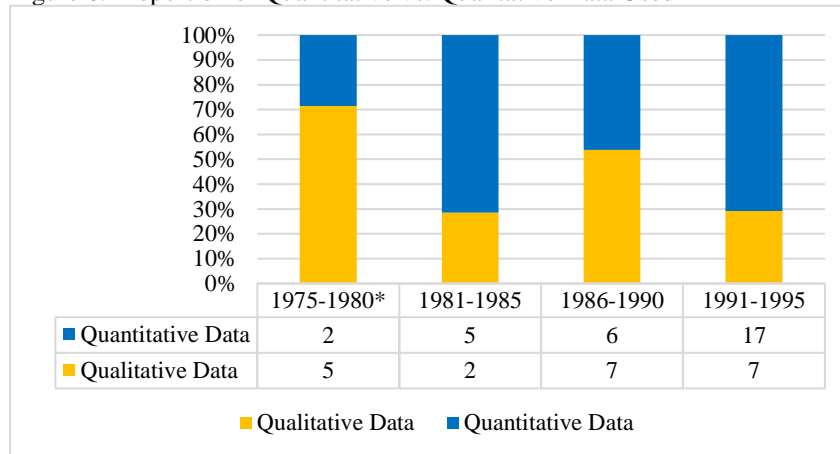


Figure 6 shows the proportion of studies using quantitative vs. qualitative data, by year published. *note that the 21-year span is broken unevenly, with the 1975-1980 span including six, rather than five, years.

Conceptualizing Grief

There was significant variance in conceptualizations of grief between theoretical orientations and across the timeframe. This section will explore the definitions of and modes used to define grief. It will also include trends that arose from the data on concepts examined in relation to grief.

Definitions of Grief

Grief was frequently defined across the sample and a range of disciplinary and explanatory modes were used. Most authors that gave a definition for grief described it as a set of emotions, cognitions, and physiological states after a loss. Some of these authors also included behaviors as a facet of grief. Throughout the definitions, authors noted variance in causes and manifestations for grief, defining it as an experience that can be brought on by various losses, lasting various lengths of time and at various severities.

In looking at the disciplinary lenses used to define grief, early definitions (before 1985) showed a strong overlap between biological and psychoanalytic understandings, often explaining physiological symptoms through psychoanalytic theories. These explanations included citing Freud and other psychoanalysts, describing grief with the language of “pining” and “yearning” in discussing theories of attachment (10 articles), and describing relations with internal representations of the lost (11 articles). Later definitions (appx. 1985-1995) were less likely to employ psychoanalytic theories, but still referred to physical/physiological symptom experiences. While occasionally using

psychoanalytic explanations, later definitions more frequently consisted of psychological experiences (e.g., guilt, distress, social withdrawal) or psychological phenomena (e.g., anxiety, depression).

Moreover, 23 authors described grief as a process. However, while early references often described grief as a series of stages, later references often described it as a multidimensional experience, with differing sets of symptoms being tracked in different times at different levels.

The results of a content analysis of the definitions for grief can be seen in Table 2. Note that “preoccupation” refers to preoccupation with thoughts of the deceased. While chronological trends were examined for these terms, there was only one notable trend: the symptom of “hallucinations,” while present in articles published in both the 1970’s and the 1980’s, was not present after 1989.

Table 2: Content Analysis of Definitions for Grief

Count	Term(s)
10	guilt
9	anger
6	despair
4	crying, depression, hallucinations, sadness
3	emptiness, helplessness, loss of interest, preoccupation, shock, yearning

Table 2 shows the incidence of the most commonly used words in definitions of grief.

When contextualized in the articles, the content of definitions for grief reveals additional slight changes. For example, while referred to throughout the timeframe, the physiological symptoms of loss of appetite and inability to sleep or work were mentioned more frequently in the second half of the timeframe (1985-1995) than in the first. These were more likely to be the key physiological symptoms listed, whereas earlier definitions often included breathing difficulties, aches resembling the pain-experiences of the deceased, etc. A follow-up content analysis for the word “function,” narrowing to references which had to do with symptoms in the individual, revealed 22 instances. The first use of “function” was in 1985, and the vast majority (16 instances) were in articles published after 1990. These references included phrases such as: “functioning as well as before [the loss],” “reduced capacity to function,” and “marked functional impairment.”

There were a few directly contradicting ideas present in the definitions of grief. For example, while some authors referred to grief as including a denial stage or aspect, others defined grief as beginning upon the acceptance of a loss, or inherently not including denial. There were no clear

chronological or genre trends here. Similarly, however, some authors described guilt as the defining feature of pathological grief, while others defined guilt as a normal part of (nonpathological) grief. These latter arguments were more prevalent in later years.

Concepts Related to Grief

Throughout the corpus, the grief experience was examined as it related to a variety of demographic and situational categories, including race, gender, age, object loss, type of loss, institutions/rituals, social support, time since loss, and individuality. Trends in each of these will be described briefly below. While not discussed here because of relative lack in prevalence, other factors examined in relation to grief include early experiences of loss, socio-economic status, prior mental health diagnoses, and aspects of personality.

Demographic Features. Many studies throughout the timeframe sought to correlate grief with various demographic variables. Age was discussed with reasonable frequency and, in general, older individuals were hypothesized to be less affected by grief because of relative exposure to loss, establishment of social roles, etc. Results varied.

Notably, only two studies examined race as a key variable in determining grief experience. Both discussed cultural rituals and spaces for expression unique to the non-white subjects, and both concluded that white subjects had more reserved expressions of grief. Additionally, two studies included samples of nonnative English speakers; both of these measured grief through a translated (from English) scale. While they had similar linguistic translation methods, only one named the possibility of a measure being non-translatable in terms of meaning.

Many articles referred to gender-based differences in experience or expression of grief, generally concluding that men are less likely to express their grief outwardly and are more likely to experience 'lower levels' of grief and resolve the experience quickly. Discussion of gender-based differences, particularly in the expression of grief, often included a discussion of societal norms (e.g., suppressing grief as a result of these expectations).

Object and Type of Loss. The factors most commonly examined as impacting loss included closeness with lost object, suddenness of loss, perceived preventability, mode of death/loss, certainty of loss, previous loss, psychological understanding of object lost, and social factors. Some authors

introduced the type of loss (e.g., of a child or by suicide) being studied as the most painful or significant of all types, and a few (solo) authors mentioned their personal experiences with certain types of loss in emphasizing the stakes of their studies. Like the demographic trends, each of these was consistent across the timeframe. Increasingly across the timeframe, some authors criticized previous research and models of grief for lack of specificity to type of loss, and research questions increasingly sought specificity.

Institutions/Rituals and Social Support. Some authors discussed the sociocultural meaning of the loss as significant to grief experience (i.e., making sense of death, rituals facilitating grief). Others described the U.S. as lacking death customs altogether, and argued that increased need for psychological help with grief was a result of this dearth. Many authors discussed the importance of social supports and social recognition of the loss as significant to grief experience. Notably, in discussing the usefulness of rituals or social supports, articles published in the first half of the timeframe (1975-1985) tended to describe their impact as one of attenuating grief severity or supporting the grief process. Representative and commonly used language includes: “adjusting to death,” “make tolerable,” “encourage ... grief work,” “facilitate grief adjustment,” “comfort,” and “encourage progress.” Articles published in the second half of the timeframe tended to shift to language that suggested the importance of grief ending, or to language oriented around symptomatology or illness. Representative and commonly used language includes: “complete grieving,” “resolve grief,” “prevent risk and ailments,” “less depression symptoms,” and “coping strategy.” While there were occasional exceptions and the data examined in this comparison of coded excerpts is small, it is still notable in light of larger trends.

Time Since Loss. Early research (1975-1985) did not place a time-limit on expected grief experience, and all articles that mentioned timeframes discussed them as being hard to predict, long, or possibly indefinite. In 1985, the first specific timepoint (18 months) was used, while others continued to argue that timeframe was arbitrary. Regardless, after 1985, there was an increase in attunement to time since loss and calls for research or measures that take that into account. Beginning in the early 1980's, there was an increase in research on the temporal course of grief, many seeking to

map specific symptom experiences on individual timeframes (e.g., anger spikes in the first few weeks, sadness ebbs and flows). There was no consensus on a specific time or course for grief.

Individuality. The factor of individual differences in grief experience was acknowledged consistently throughout the articles. Some authors argued for the consistency of their proposed models, for instance, regardless of individual differences, whereas others noted that their models were not consistent because of this factor. Previous interview or case study research was at times criticized on account of individual differences, with suggestions that quantitative research would be less influenced. There was particular emphasis on taking individual differences into account directed toward mental health professionals, and little mention of acknowledging individuality in research itself.

Conceptualizing Pathological Grief

Overlapping and intertwined with – and at times intentionally separate from – conceptualizations of grief, many articles defined or discussed pathological grief. Whether as a physiological experience or a psychological process, as a severe dimension or a discrete diagnosis, or as a combination of all of these, the meaning of pathological grief was in no way unanimous. This section includes an examination of the trends in definitions of pathological grief, as well as discussions of concepts presented as relevant to pathology throughout the discourse.

Defining Pathological Grief

Definitions of pathological grief took a variety of forms, including lists of physiological symptoms (e.g., “tightness in the throat, shortness of breath, sighing, loss of appetite, loss of sleep, and emotional waves;” Bugen, 1977, p.199), lists of psychological symptoms (e.g., “guilt, anger, resentment;” Sprang, McNeil, & Wright, 1992, p.146), lists of behaviors or actions (e.g., “failure to find new or restore old rewarding patterns of interaction;” Bugen, 1977, p.201), or lists of other phenomena (e.g., depression, post-traumatic stress, anxiety). Table 3 shows the results of a content analysis for definitions of pathological grief. It should be noted that the terms “chronic,” “prolonged,” “complicated,” and “delayed” all refer to categories of pathological grief.

Table 3. Content Analysis of Abnormal Grief

Count	Term(s)
14	depression
6	chronic, prolonged
5	delayed, guilt
4	absent, crying, deceased, sleep
3	complicated, coping, failure, grief, intense, preoccupation, yearning

Table 3 shows the incidence of the most commonly used words in definitions of abnormal grief.

While most of the terms used did not reveal chronological trends, a few did. For example, “crying” was not mentioned as a symptom of pathological grief until 1989. Only one reference for crying used a refining word (“uncontrolled”). Additionally, the word “coping” was not used in definitions of abnormal grief until 1991, and “yearning” was not used until 1995 (by multiple authors). The term “prolonged,” while among the most commonly cited, was not used after 1991. “Complicated” was not present until 1991.

Many theoretical lenses were adopted in delineating pathological grief. The most common explanation for pathological grief was that it was a discrete entity. While some definitions argued that pathological grief consisted of the same symptoms or experiences as nonpathological grief, simply more severe or longer-lasting, others argued that it was characterized by a discrete set of symptom experiences. Moreover, commonly cited descriptions of pathological grief included those of Freud and Lindemann, reflecting a psychoanalytic or process-oriented understanding, or understandings wherein pathology took the form of absent, delayed, prolonged, intense, or acute grief. These were cited with reasonable consistency throughout the timeframe, but later authors tended to nuance or add more recent research to older definitions, as will be detailed later.

Similar trends were seen in the use of models to understand the grief process. The most commonly referenced model for grief was that of Bowlby (and sometimes coauthor Parkes). Other models for grief included Kubler-Ross’s and Freud’s – each of these was mentioned no more than three times. Critiques of previous grief models frequently entailed that they were overly simple, overly linear, not supported by empirical evidence, or contrasted with other evidence/theories. These critiques were present only in articles published after 1984. Some critiques argued that grief is

incapable of being mapped onto a model, while others proposed new, more dynamic models or called for research more oriented toward dynamic, personality- or loss-related features.

Concepts Related to Pathological Grief

A number of phrases and concepts arose in the processes of open and axial coding. Examining these smaller subsets of coded material more closely, some exhibited trends that might reflect the larger changes in conceptualizations of pathological grief. These included long-term implications of grief, references to the multidimensionality of grief, references to ‘depression,’ uses of ‘construct,’ and uses of ‘normal.’

Long Term Implications of Pathology. In the first years of the timeframe (1975-1982), authors frequently argued for the study of grief by describing increased morbidity and mortality as a long-term effect of bereavement/grief. In the second half of the timeframe (1989-1995), references to increased morbidity and mortality after bereavement/grief had decreased significantly and, when present, were almost exclusively described as a result of pathological grief. Some authors cited long-term mental health impacts of bereavement/grief; these were quite consistent across the timeframe.

Multidimensionality. Grief was frequently described using phrases such as: “multidimensional,” “complex,” “variety of emotional states,” and “multiple processes.” These descriptions were used consistently throughout the time frame. Notably, many of these were in the context of discussions about measures. Measures were both developed to reflect the multidimensionality of grief and used to gather information about it, particularly in later years.

Depression. The modes and content of references to depression were notably inconsistent. Throughout the data, depression was referred to as: a symptom experience of normal grief, a key feature of one of the stages of normal grief, a key feature of pathological grief, a discrete syndrome/diagnosis which must be distinguished from grief, and a discrete syndrome/diagnosis with significant presence in grieving samples or high comorbidity with complicated grief. Some authors referred to depression as both a discrete diagnosis and as a symptom of grief within the same article. Perhaps reflecting and shaping this, measures for depression were at times used to measure severity of depression experience among the bereaved, even as they were at other times used to ensure that grief-measures only took into account grief (and not depressive) experiences.

Normal. Words most commonly used to refer to a grief response or experience that is expected and/or non-pathological included: normal, appropriate, inevitable, and universal. In the contexts of these articles, words for normalcy seemed to take on one of two key meanings: first, as a description of responses that were expected in light of losses/culture/context; and second, as a category of grief response, in contrast to pathological, acute, chronic, complicated, etc., forms of grief. The first meaning was used much more densely in the first half of the timeframe (1975-1985) and, when used, little detail was given. The word ‘normal’ was, in these cases, a self-explanatory adjective, not a new category – for example, “grief is a normal reaction to loss.” The latter meaning was used, and was taken-as-fact, with increasing frequency throughout the second half of the timeframe. It was often presented immediately before or after a definition for some form of pathological grief. There were occasional exceptions to the timeframe trend.

There seemed to be more explanation put into defining the meaning of “normal” after the 1970’s, and this increased slightly throughout the timeframe. Two definitions for normal grief posited that the basis of determination was the individual and their standards (Engel, 1980; Brabant, 1989); all other definitions for normal grief (the discrete category) sought to outline more universal symptom or process descriptions. Some authors described measures as the main tool for differentiating normal from pathological/non-normal grief experiences.

Construct. References to grief and related theories as a construct were relatively sparse. The key exception to this was one of the aforementioned theoretical outliers, published by Wambach in Omega in 1985, which explored the internalizations and impacts of grief as a construct. Some of the references to grief as a construct beyond this article were in the context of discussions of measures: “future attempts to validate the [measure] will necessarily involve validating the construct of grief itself” (Faschingbauer, DeVaul, & Zisook, 1977, p.697), and “we wondered to what extent these analyses would support the constructs of attachment theory that guided the development of the items” (Jacobs et al., 1987, p.41). While not frequently repeated throughout the corpus, these mentions are significant in that they evidence the role of measures in cementing reifying definitions of grief. There were no references to grief as a construct after 1988.

Grief-Related Concepts

In addition to these consistencies and changes in definitions of grief and pathological grief, this section will explore a few closely related concepts that are not included in these categories but are nonetheless important to a full understanding of the conceptualizations of grief. These include related phenomena/forms of grief and definitions of ‘recovery.’

References to Other Grief

A variety of grief-related phenomena were described throughout the data. For example, multiple authors discussed anticipatory grief, often arguing that it led to less intense post-death grief experiences. Mourning was also described reasonably frequently, particularly in the first half of the timeframe. The definition for mourning shifted slightly over time, from a long process of which grief was a component (consistent definition in the first half) to, when mentioned, activities, behaviors, and rituals associated with beliefs or public aspects of grief. Thorough definitions of mourning were not consistent enough to draw any firm conclusions about these trends. Relatedly, language used to describe grief-related phenomena/syndromes tended to increasingly move toward a symptomatic understanding of grief across the time frame – for example, from “anniversary reactions” to “subsequent temporary upsurges of grief” (Adamolekun, 1995). While instances like this were again sparse, they seem reflective of broader changes in the phenomena surrounding grief.

Recovery

Recovery was often referenced as the aim of individual or therapeutic work or as the end that was not reached in instances of pathology. Many descriptions of recovery included mentions of reforming or regaining habits of ‘before’ life. The idea of ‘grief work,’ and the theories of Lindemann, were cited reasonably consistently throughout discussions of grief resolution. Later years brought a few more challenges to these theories.

The meaning of this term seemed to change slightly, particularly in the last few years of the timeframe. A content analysis reveals that, of 29 articles to use the word “resolution,” 24 (82.7%) were published after 1985. Additionally, articles published between 1990 and 1995 evidenced an increase in refining words that presented recovery as resolution that was “successful,” “healthy,” “appropriate,” or that “end[ed].” There were a few instances of this refining language in earlier years,

but a notable increase in the last five years. Content analyses affirm this trend: of 17 articles to use the word “unresolved,” 14 (82.4%) were published after 1985. Additionally, of the 25 articles to use the word “appropriate,” 21 (84%) were published after 1985; of the 20 articles to use “successful,” 16 (80%) were published after 1985; and of the 20 articles to use “healthy,” 16 (80%) were published after 1985. While recognizing the relative increase in number of publications between 1975-1985 (n=24, 34.3%) and 1986-1995 (n=46, 65.7%), these trends seem notable.

Similarly, while multiple earlier (pre-1991) descriptions of resolution included statements along the idea that a loss is something that one never truly gets over, definitions of recovery in the 90’s, and particularly after 1993, were significantly less likely to include this idea. These post-1990 descriptions also defined recovery in terms of function or productivity, wherein resolution entailed regaining previous levels of function. Earlier definitions much more frequently described finding or attaining new habits or states of equilibrium.

Studying Grief

As mentioned, the corpus contained a wide range of studies, from theoretical propositions, to reviews of articles, to correlational examinations. In order to understand key commonalities and changes across the dataset, I focused on the articulation of research questions, the purposes stated for researching grief, and the suggested sites of intervening into the grief process. In this section, I will discuss the trends that arose.

Research Questions and Purpose for Researching

A variety of motivations were named in introducing studies. The most common were: a lack of previous research, the need to correct or improve upon previous research, the importance of studying grief because of the suffering implicated in the experience, the need to predict the grief experience, and the need to intervene.

Lack of previous research on a topic was present in rationalizations consistently throughout the sample. This included statements such as, “literature is generally silent,” “need for extensive research ... about,” “gap in the literature,” and “relatively little research.” Less commonly, but nonetheless consistently, rationalizations for researching grief across the timeframe described the

physical and psychological stakes of the grief experience. This included both descriptions of the general suffering caused by grief and references to situational needs among specific groups, such as an increase in the population of widows or poor outcomes among certain populations that might be related to grief.

Closely related, later years saw an increase in language suggesting a need to be able to predict grief outcomes, particularly to discover factors or situations which might result in maladaptive or poor outcomes. While this was present to some degree in the first half of the timeframe (3 mentions before 1985), frequency of this motivation increased significantly in the second half (10 mentions after 1985). Notably, three articles (Toedter et al., 1988; Lasker & Toedter, 1991; Worden & Silverman, 1993) mentioned that their studies came in part as responses to a 1984 call for research into “the specific factors that may place individuals or groups at a high risk for poor outcome following the loss of someone else” (Lasker & Toedter, 1991, p.510) made by the Institute of Medicine’s Committee for the Study of Health Consequences of the Stress of Bereavement.

The latter half of the timeframe also saw a significant increase in research rationalized by weaknesses in previous studies or models for grief (2 mentions before 1985, 11 mentions after 1985). The criticisms of previous research fell largely into two main categories. Less frequently, studies articulated criticism of previous research methods, such as “not empirical,” “sparse,” “unsystematic,” and “methodologically questionable.” Instances that fell into the second, more frequently cited, category described a lack of specificity in previous research. This criticism included language that aligns with previously mentioned trends on the increasing need to conceptualize grief as a multidimensional object, such as a “need to delineate interrelationships among different variables” (Sprang et al., 1992, p.158). Other criticisms included a need to modify measures or models to apply to specific types of losses or fit more recently proven theories/findings.

A final key category used to rationalize the study of grief was the need to intervene in the grief process in an effort to prevent or relieve suffering. This motivation also increased significantly throughout the timeline, with 2 mentions before 1985 and 8 mentions after. Interestingly, within these arguments for the creation or implementation of interventions, there was a certain vagueness that seemed to suggest an increasing assumption (particularly in the last five years of the timeline) that

pathology would occur in the absence of an intervention. In other words, there seemed to be an implication that intervention in the context of psychological expertise is necessary for a successful or healthy grieving process. This contrasts with earlier language, which was more likely to recommend intervention among those exhibiting or predicted to exhibit pathological grief. Though this trend is less strongly present in the current data, the shadow of it that does exist, particularly between 1990-1995, is significant in that it evidences the groundwork being laid for modern conceptualizations of (and diagnoses for) grief.

Relatedly, the two thematic outliers, which researched the institutionalization of bereavement, both discussed the stakes of such research being the internalization of non-universal (constructed) processes. For instance, one described the “choreographing” of grief to the extent that “it appears that there is a script to follow and that improvisation (genuine communication among people) is discouraged” and that “deviat[i]ons” from expectations for “appropriate” responses receive diagnosis rather than care (Irving, 1992, p.7). The other described an instance of grief-course comparison, such that individuals in groups meant for peer support would instead internalize benchmarks of improvement as necessary at certain times when they were enacted by groupmates ‘further along’ in the grief process (Wambach, 1985).

Site of Intervention

Given that many articles articulated the importance of addressing certain types of grief at certain stages, additional attention was paid to descriptions of intervention throughout the corpus. There were multiple facets to these mentions.

Is Grief Treatable? Five articles implied that grief is not an experience that requires treatment, and instead used phrases such as “not an illness,” “a natural part of life,” or a process which “must run its course.” However, the last of these mentions was in 1986; references to intervention after this time were silent to the notion that grief be allowed to “run its course,” or spoke in direct opposition to this idea, as will be seen in the following sections.

What Grievers Need Treatment? Consistently throughout the timeframe, rationalizations for the creation or modification of models or measures included reference to the importance of identifying pathological grief, and thus determining who should receive treatment. Even as these

specifications that only pathological grief should be tracked and treated were consistent throughout the timeframe, the latter half saw a significant increase in the number of articles that articulated grief – without the specification of pathology – as requiring treatment or expertise (1 mention before 1985 and 13 after). This was evident most frequently in statements that implied that a mental health professional is necessary in order to “facilitate grief work,” to support “a successful coping process,” or that “appropriate interventions” are necessary “to assist the bereaved.” This emphasis on the need for clinical expertise to navigate any grief experience, even while coexisting chronologically with studies that did specify that only pathological grief requires treatment, is notable.

Who Should Treat Grief? This trend of the necessity for clinical expertise to control the care of grief was also evident in references to the individuals who should be intervening. Articles throughout the timeframe discussed the importance of rituals, social support, community spaces, and clinical spaces as the main sites of care or intervention. Notably, two of the three mentions of rituals referred to these as practices of the past or of non-American cultures, and discussed the need for other spaces or modes of expression in their absence. Moreover, over the span of the timeframe, there was a significant increase in mentions of training or expertise required to effectively support grieving individuals. For instance, while early articles suggested that “teachers,” “clergy and funeral directors, among others,” and community members could provide “support of grief work,” the later years contained little to no mention of these possible supporters. In fact, all but one of the thirteen references to treatment or care of grief after 1987 referred to some form of psy-discipline expertise. These included “therapists,” “highly trained clinician[s],” “counselors,” “mental health professionals,” and those trained to administer “specialized treatment.” The one exception to this trend was an article that argued that teachers could play a role in supporting grief reactions, but only if trained by mental health professionals. Further, though sparse, even mentions of the role of social support in assisting the grief process were more likely to include reference to the role of a professional in organizing groups or “systematically involv[ing] the surviving family members in mutual aid or social support networks” (Sprang et al., 1992, p.157). This suggested that traditions of community responses to loss also transformed into objects of clinical expertise.

Measuring Grief

I have so far presented evidence for the changing conceptualizations of and research-approaches to grief. One goal of this research is to examine not only the possibility of grief's medicalization, but also the nature of its operationalization. Focusing in on studies that made use of quantitative data, this section will explore the motivations for making measures, the processes used to develop measures for grief, the use of measures, and the content of measures for grief. It will also briefly explore uses of qualitative data in the corpus.

Motivations for Measure Development

The first systematic measure for grief, the Texas Inventory for Grief (TIG), was published in the *American Journal of Psychiatry* in 1977. Close examination of the motivations for developing this measure is important both because of its novelty and because it was used frequently to measure grief and to guide the creation of later measures.

The authors of the TIG introduced their work by writing that, “unfortunately, the construct of grief has never been adequately operationalized and validated” (Faschingbauer et al., 1977, p.696). They expound on the “unfortunate” nature of this fact by discussing the ways in which a reliable measure will allow for ““abnormal grief” [to] be statistically definable (e.g., a score greater than 2 standard deviations above the normative sample mean) and ... to arrive at various cut-off levels, with known percentages of hits and misses, for various psychiatric and medical symptoms” (Faschingbauer et al., 1977, p.697). In addition to becoming a tool for evaluating the relative normalcy of an individual's grief experiences, the authors write, “we are optimistic at this point that the TIG or some similar scale can eventually offer a brief screening tool and a means to evaluate existing grief theory more systematically” (Faschingbauer et al., 1977, p.698).

These statements and suggestions can be seen at work in the uses of measures throughout this corpus. After the development of the TIG, studies that included the creation of a new measure often articulated a need: 1) for a quantitative operationalization of a specific grief experience (e.g., perinatal loss, non-death loss, pathological grief, complicated grief), or 2) to test and allow for a more specific or developed understanding of grief (e.g., to separate grief from depression, to test a multidimensional model for grief). Three measures, including the TIG, were developed before 1985 and seven

measures were developed after, evidencing a general increase in systematic measure creation.

Interestingly, a few studies built on the discourse of the TIG's authors, with motivations or hopes that included: making a measure to "better understand the process as well as to better delineate the boundaries between normal and complicated (i.e., unresolved, morbid, distorted, atypical, absent, delayed, chronic, abnormal) grief" (Zisook, DeVaul, & Click, 1982, p.1592) and making a multidimensional measure for grief to "illustrat[e] that grief reactions are multidimensional" (Vargas, Loya, & Hodde-Vargas, 1989, p.1488). There was little mention in these articles of the methods used to delineate ab/normal grief beyond the measure.

Moreover, many later measures were developed to address weaknesses in existing grief inventories. Critiques of previous research using quantitative measures included that measures for related phenomena were used as (not-fully-representative) proxies for grief, and that measures did not take certain models, causal factors, dimensions, or situation-specific manifestations of grief into account. Because of relative sparsity of these critiques, trends are difficult to detect; in general, each of these critiques was referred to with relative consistency across the timeframe.

Developing Measures for Grief

Among studies that developed a measure for grief, four main methods were used: gathering descriptions from literature reviews, interviewing participants in a study and including items that were repeated with statistical significance, developing items based on theories, and gathering items from previously developed measures. The literature review method was used most commonly (5 times – 1976, 1988, 1989, 1991, 1995), followed by the gathering of items from previous measures (3 times – 1988, 1992, and 1995). The other methods were each used once, interviews in 1977 and theory in 1987. The relative sparsity of this data prevents any conclusion on trends, aside from the general emphasis on the use of literature. Studies that employed validation protocol all described processes either of delivering the measure to larger or more situationally diverse groups and completing factor or components analyses to verify inter-item consistency or of comparing findings of the measure with previous research or theory (e.g., that symptom severity generally decreases over time).

One striking example of measure development came in the 1995 creation of the Inventory for Complicated Grief, one of the last measures created within the corpus. While measures had

previously been designed to suggest a cutoff score at which abnormal grief might be diagnosed, this was the first measure developed for the sole purpose of identifying pathological grief. It should be noted that this research group operated – and developed the measure – under the assumption that complicated grief is a “distinct” disorder separate from “bereavement-related depression” (Prigerson et al., 1995, p.24). While arguing for complicated grief as a distinct disorder, the authors developed the measure by a process of: “1) a review of the literature in order to select symptoms associated with poor adjustment to bereavement, 2) selection of symptoms expected to be the most potent predictors of long-term dysfunction on the basis of clinical experience and intuition, and 3) use of principal-components analysis to determine how the chosen symptoms clustered together and whether they were separable from symptoms of depression” (Prigerson et al., 1995, p.24). Most, if not all, of the symptoms gathered from previous studies were identified by the use of previous measures (including studies published by Zisook and Jacobs, described in this corpus). Moreover, hypothesized characteristics of pathological grief were tested by their inclusion in the measure: “worthlessness, suicidal ideation, and psychomotor retardation, listed in DSM-III-R as the hallmarks of complicated bereavement, were included to determine whether they would cluster into a complicated grief factor distinct from bereavement-related depression” (Prigerson et al., 1995, p.24). In other words, the content of a measure for complicated grief came not from a pre-existing definition for the “distinct disorder,” but instead from a combination of findings from other measures, as verified by internal consistency tests (Prigerson, 1995, p.24).

Content of Measures

Table 4 shows descriptive information for scales used or developed in the surveys. The number of items in a measure varied from 7 to 135. All measures developed used point-scales, and the vast majority used 5-point Likert scales. Scores on the lower end of the scales generally referred to symptom experience of “no problem,” or “never or rarely,” and increased in severity along the scale. Most measures were used to differentiate pathological grief from non-pathological grief, using a binary between the two at a set cut-off score. One measure separated participants into three groups: “Well Adjusted,” “Moderately Adjusted,” and “Depressed” (Doka, 1984, p.125).

Table 4. Descriptions: Measures Used

Year Used	Number of Items	Type	Number of Dimensions or Subscales
1976	8	5-point Likert	n/a
1977	7	5-point Likert	n/a
1987	13	1-9 scale	n/a
1988	84	5-point Likert	21
1989	20	4-point Likert	4
1991	33	5-point Likert	3
1991	37	Not stated; implied Likert	4
1991	29	5-point Likert	n/a
1991	21	5-point Likert	2
1991	135	Not stated; implied Likert	12
1992	8	5-point Likert	n/a
1992	13	5-point Likert	2
1993	20	4-point Likert	n/a
1994	Not stated	Not stated; implied Likert	12
1995	18	5-point Likert	n/a

Table 4 shows information on the length, form, and structure of the measures used.

Using Measures

Beyond studies with the main aims of developing or validating measures (10 total), other studies that used measures (20 total) did so most frequently to correlate grief experiences with other variables, particularly demographic (e.g., age, race, gender), situational (e.g., type of loss, presence of rituals or supports, personality features), or with other symptom experiences (e.g., depression, ventilatory experiences, distress). The overall frequency of these studies increases significantly over the timeframe, with 3 published before 1985 and 14 published after. This is likely representative of aforementioned increases in emphasis on predicting and understanding dimensions of the grief experience, as evidenced by increasing specificity in the populations and variables studied. This increase may also be related to the number of measures available for use over the timeframe, and to increasing disciplinary emphases on quantitative data.

Moreover, multiple studies made use of quantitative measures for non-grief psychological phenomena. Most notably, though relatively sparse, trends in measures for depression used seem to affirm aforementioned depression-related trends. While depression inventories (Hamilton Rating, Beck Inventory) were used to measure grief in one study in 1985 and to measure depression related to grief in 1986, these same measures were used in 1991 and 1995 (twice) to ensure that factors being

measured by grief scales were not related to experiences of depression. While slight, this is important to broader understandings of grief.

Qualitative Data Usage

While the focus of this project is on the role of quantitative measurements for grief, there were many studies in this corpus that used qualitative data as their main source. The rationalizations mentioned alongside these decisions add context to the discourse in this cultural moment.

The most common form of qualitative data used was a semi-structured interview. Among studies using qualitative methods, semi-structured interviews were reasonably consistent throughout the timeframe. Other forms of qualitative data included notes from psychoanalysis or clinician's descriptions of their patients (used twice, 1979 and 1980), ethnographic fieldwork (used twice, 1980 and 1985), and systematic rating of written responses (used once, 1994).

Two trends are notable in the use of semi-structured interviews. First, multiple studies used a combination of semi-structured interviews and quantitative measures (some of which were delivered auditorily). This choice was relatively consistent across the timeframe. It was not always clear the degree to which each data source was weighted; for example, one article mentioned that interview data suggested "that participation in planning and conduct of funeral rituals seemed to aid adjustment to death," but, because there was no significant difference on the quantitative scales, they failed to prove their hypothesis (Doka, 1984, p.122). Most other articles that used a combination of quantitative and qualitative data did not reference decisions like this, so it is difficult to know which type of data was prioritized.

Second, an interesting trend began to arise in the later years of the timeframe. While interviews were used consistently, beginning in 1989, description of this methodological choice was frequently accompanied by an anticipation of arguments. In all articles published before 1989, the qualitative choice was introduced as unquestioned, with statements silent to alternatives, such as, "administered a semistructured interview designed to obtain data pertaining to the recent bereavement" (Schuchter et al., 1986, p.879) or "all subjects were administered 1) a semistructured interview to evaluate the circumstances of their infant's death..." (Jellinek, Goldenheim, & Jenicke, 1985, p.121). In contrast, mentions of choice in three of the five interview studies 1989 and later

included such language as: “although there are several ways of approaching the present research question, the interview was seen as the alternative of choice. This is because...” (Calhoun & Tedeschi, 1989, p.267), “most of the reviewed studies used standardized questionnaires to investigate perinatal loss. In contrast, the primary interest of this project was in parents’ accounts of their grieving process” (Thomas & Striegel, 1994, p.301), and “the sensitive nature of the topic and the desire to understand grief within a social context, meant that a flexible research design was needed, one that was...” (Rowling, 1995, p.319). The rationalizations all mentioned the importance of ascertaining the perceptions of the bereaved directly, “in their own language and interpretive framework” (Calhoun & Tedeschi, 1989, p.267) or the importance of efforts that “minimized the distance” (Rowling, 1995, p.319) between researcher and participant. Additional rationalizations included references to the frequency of interview methods in previous work with bereavement, advantages of interview work for exploratory studies, and the importance of attunement to various contextual variables when discussing grief. While this trend is recognizably sparse, I argue that it might reveal the beginning of shifting priorities in the larger fields of the psy-disciplines.

Contexts of Grief Research

A final set of codes allowed for examination of the contexts of grief research, including references to the broader cultural changes occurring, mentions of the types of expertise related to the study and treatment of grief, attitudes toward the field of grief studies, and descriptions of a few key leaders in the field. The aim of these codes was to track the transitions of and within grief studies as placed in larger societal and psy-discipline moments.

Cultural Views of Death and Grief

A significant factor in perception and treatment of grief in this era could be seen in descriptions of the role of cultural views on death, the de-institutionalization of rituals relating to death, and changing cultural perceptions of (negative) emotional expression. It must be noted that these expressed cultural movements and the role of psychiatry in defining normalcy and medicating forms of expression are inextricably intertwined. Nonetheless, the references to cultural changes and

perceptions throughout the timeframe of this corpus are notable in understanding narrations of these changes from within the psy-disciplines.

First, as described in the discussion of factors related to normal grief, there were multiple references to the influence of social perceptions on the expression of grief among certain groups, including men, individuals grieving the death of an unborn child, and individuals grieving an individual who died by suicide. These mentions were relatively sparse and consistent throughout the timeframe.

Second, there was a notable lack of consistency of references to the relationship between described cultural tabooing of death, described cultural discouragement of expression, and the role of psychiatric research. For example, one article cited the U.S. as a culture in which death is taboo, and argued that this is a reason for the lack of research into grief (Ball, 1976). Another described current increases in research on death and mourning as contributing to “increasing social acceptance of the broad range of human grief reactions” (Bugen, 1977, p.196). Moreover, a few articles described the relative lack of – or active decrease in – mourning rituals in U.S. society as either creating a need for psychological expertise and guidance or resulting in pathological grief experiences. One of the thematic outliers even suggested that the grief process (as a multi-stage construction) has become a “less formal” proxy for “mourning rites” in U.S. culture (Wambach, 1985, p.202). Importantly, there were no mentions of these rituals (or lack thereof) after 1986. In fact, references to culture after 1986 were silent to communal rituals or practices of expression, instead using descriptions such as “our culture does not encourage the free expression of intense emotions” (Widdison & Salisbury, 1989, p.299) and “the population as a whole does not tend to openly express grief associated with any death” (Carson, Warren, & Doty, 1994, p.193). Expression of grief in the context of these discussions was frequently referred to as “do[ing] one’s ‘grief work’” and “developing coping mechanisms.”

Domains of Expertise

Building on the aforementioned discussion of the roles considered in regarding the treatment of grief, an additional code was used to explore the more general allocation of expertise over grief. Because there was significant overlap between these quotes and those referring to treatment, trends were similar. Most references to expertise mentioned physicians, counselors, social workers, and

other mental health professionals. Anthropologists were mentioned a few times as providing expertise on grief experiences and rituals, particularly in non-U.S. contexts. There were 4 references to clergy, religious communities, pastoral counselors, or funeral-professions, the latest of which was in an article published in 1986.

Two excerpts, though sparse, presented a striking description of the role of mental health professionals. Both of these articles were published after 1990. The first article, discussing the presence of bereaved children in a school setting, wrote that, “since the trauma of death can cause severe disruption to a person’s life, it has been recommended that support programs be directed to all segments of the population” (Carson et al., 1994, p.192). Similarly, the second article described:

“Mental health professionals have a role to play in helping bereaved elderly adults. However, because the bereaved do not see themselves as psychologically disturbed, they do not generally seek mental health services. Education and outreach to the community to let the bereaved know they are understood, ... that they can have someone with whom to share grief, and that they can explore options for new plans and relationships could help mitigate its distress.” (Sable, 1991, p.139)

I argue that these were notable in that they may evidence the beginning of a trend emphasizing the importance of psy-discipline expertise in identifying and tracking grief among all individuals, not only those who see an issue in their own experience.

Attitudes toward Previous Research

In introducing specific research questions or methods, many authors expressed views about the state of the discipline and previously conducted research. Among these attitudes, a few common themes became clear.

Reflective of trends seen in other subsets of the data, there were frequent mentions of the operationalization of grief and the standardization of research methods on grief. There were only two mentions in this theme before 1986, observations in 1977 and 1982 that “operational definitions ... seem to be a natural part of our future research” (Faschingbauer et al., 1997, p.698) and that many details of the grief process were “still uncharted” (Zisook et al., 1982, p.1590). Beginning in 1986, there was a significant increase in these comments (13 mentions), and the attitude seemed to acquire a sense of criticism. The three key evaluations, often intertwined, were that grief had not been adequately operationalized, that the differences between normal and pathological grief had not been

clearly defined, and that previous research was not standardized or systematic (often because of its qualitative nature). For example, previous definitions were critiqued for being “unclear” and “not clear cut” and for relying heavily on “various theoretical models of grief” and lacking “empirical foundation.” Commonly used descriptors for previous research methods included language such as: “sparse” and “lack[ing];” “qualitative in nature” and “based on small ... [or poorly chosen] ... samples;” and “unstandardized,” “unsystematic,” and “methodologically questionable.” The creation of a measure for grief was almost always mentioned as the needed solution in discussions of these issues.

Notably, five articles to offer refinements of the act of studying and treating grief within the psy-disciplines shared the critique that current models were overly simplistic or removed from the realities of the experience. Representative of these evaluations, one author wrote: “grief is an entirely chaotic experience. When grief is presented in textbooks and lectures, the so-called stages are always listed in an orderly way” (Wroblewski, 1984, p.178). Similarly, when referring to the reality of grief, authors wrote (with the tone of critique) that “most teaching exercises on grief and mourning take place in an intellectual, scholastic atmosphere,” producing distance between student-counselor and client (Engel, 1980, p.45), and that “much of the clinical literature of parental bereavement fails to convey adequately the intensity and depth of feeling which accompanies the death of a child” (Koocher, 1985, p.148). It is important to hold these critiques and observations together (and in contrast) with the aforementioned critiques more frequently cited throughout the discourse.

In connecting the study of grief more formally to the psy-disciplines, DSM-III R, published in 1987, was first mentioned in this corpus in 1991. It was mentioned a total of three times (1991, 1993, and 1995), each time a reference to the distinction it made between “normal bereavement” and “depression.”

References to Key Scholars

Throughout the corpus, a number of authors were consistently named for their significant contributions to and shaping of the field of grief studies. These authors included Sigmund Freud, Erich Lindemann, John Bowlby, Colin Murray Parkes, and Elisabeth Kubler-Ross.

Freud. The work of Sigmund Freud, the Austrian founder of psychoanalysis, was cited in 17 articles and described as significant to the endeavor of grief studies. Of his scholarship, *Mourning and Melancholia*, published in 1917, was cited most frequently. Freud was described by some authors as “providing the setting for,” or exploring with a “pioneering nature” conceptualizations of the differences between grief and depression. About half of the references to Freud’s work were accompanied by refinements or critiques (i.e., oversimplified, disagrees with recent findings); the presence of these nuances was relatively consistent across the timeframe, and no significant trends were noted in attitudes.

Lindemann. German-American psychiatrist Erich Lindemann was cited consistently (in 25 articles), with the majority of these citations describing his definition of grief. He was frequently referred to as the first to define grief, and the differentiation between normal and pathological grief that he proposed in 1944 was described as significant. While referenced throughout the timeframe, four articles (one in 1982 and three after 1990) provided critiques or nuances to his research based on more recent findings or models. While notable, this does provide sufficient evidence for a significant trend in views of Lindemann’s work.

Bowlby. British psychologist, psychoanalyst, and psychiatrist John Bowlby was cited by 21 articles in the corpus. He was described most frequently for his work on grief models based on understandings of development, attachment, and separation, which were first published in 1961. Bowlby was a prolific author in this topic, and many of his later publications are also cited. He was described as both publishing significant work and as shaping the work of many later scholars. One article (Klass, 1987) was dedicated to critiquing Bowlby’s model in light of Freud’s theories on identification. This was the only article to critique Bowlby’s work.

Parkes. The work of British psychiatrist Colin Murray Parkes was also cited consistently throughout the timeframe, in a total of 27 articles. Like John Bowlby, Parkes published many studies relevant to discourse on grief, beginning in 1965. He was cited most frequently for outlining phases of grief using attachment theory, for suggesting multiple categories of pathological grief, and for many applied studies. He collaborated with Bowlby, and his impact was often described alongside Bowlby’s. Only one article, published in 1995, presented significant critique of Parkes’ theories.

It is important to note that both Bowlby and Parkes continued publishing with relative frequency into the timeframe of this corpus, and this may have contributed to the degree to which their work was (not) cited with critique.

Kubler Ross. Of these authors, Elisabeth Kubler Ross, a Swiss-American psychiatrist, was mentioned least frequently. Her work on stages of dying (often also applied to grief), published in 1969, was cited by seven authors, the vast majority (6) in or before 1985. There was minimal commentary on the process that Kubler-Ross presented, with most authors describing it as influential, particularly in inspiring future research or in being a significant early model.

Discussion

In her ethnographic analyses published within this project's dataset, communications scholar Julie Ann Wambach wrote that "the grief process was accepted by widows and professionals as a fact that was not contestable" (Wambach, 1985, p.201). In this project, by examining the discourses published in the eras of Wambach's writing, I aim to learn more about the formation of that which we now take as "not contestable" (Wambach, 1985, p.201). As sociologist David Garland cites Foucault, I hope to see what might be "disturb[ed]" among "what was previously thought immobile" (Garland, 2014, p.372; citing Foucault, 1991, p.82). It is important to examine past eras of psychiatry because the decisions, arguments, and changes put in place, the avenues pursued and those left unexplored, set "the conditions of existence upon which present-day practices depend" (Garland, 2014, p.372). While the history of focus in this project is quite a recent one, the trends that arose in analysis are nonetheless significant in grounding our understandings of the powers and moments "that gave birth to our present-day practices" (Garland, 2014, p.372). As stated earlier, I do not do this in the hopes of pointing to an alternative 'right' articulation, expression, or treatment of grief, nor in claiming that pre-1980 conceptualizations of grief were superior. Rather, my goal here is to shed light on the ways of being, feeling, and grieving silenced or deemed pathological in the production of psy-discipline 'grief.'

Structure and Notes

First, it must be reiterated that each of the small trends observed in the data are just that: small. They are notable within the subsections of the larger corpus in which they were coded, but it is difficult to speak to the significance of any one trend or code across the corpus. That said, the analysis identified three key threads among these smaller trends that begin to suggest answers to the guiding questions on the changes that took place in conceptualizations of and analytical approaches toward grief during the years surrounding DSM-III's publication, and on the role of measures in these transitions. These three threads are that: 1) conceptualizations of grief increasingly aligned with the priorities of a new psychiatry, 2) increasing emphasis was placed on specificity and predictability, and 3) definitions of pathology increasingly opened up to include formerly non-pathological experiences. In this section, I will first present a few general notes to foreground some of the choices and assumptions in the discussion. I will then give detail to the three threads as they appear in the data, as operationalization influences them, and as they align with or challenge previous research. While the development of measures is intertwined with many of the key aspects of these threads, I will explore measures separately in the discussion of each thread in order to ensure a more full understanding of the role they played. I will then weave these threads together, using key theories and models to discuss the broader implications of these changes as they relate to previously made claims and as they expand on them, particularly regarding the significant part played by operationalization. I will also discuss limitations of the research and areas for further explanation.

On U.S. – International Influence

The few non-U.S. articles present in the corpus, 80% of which were published in the Global North, were notably consistent with U.S. articles in terms of methods and conceptualizations of grief. Additionally, all of the scholars cited throughout the data as significant to the field of grief studies (e.g., Freud, Bowlby, Lindemann, etc.) were from or had partial citizenship with European countries. These consistencies, though small, seem to evidence an international transference of grief theories and of psychiatric methods more generally within the Global North. With my analysis centered on the years surrounding the publication of DSM-III, this concordance speaks to the power of this cultural

moment in U.S. psychiatry as one that may have shaped, even as it may have been shaped by, broader Global North trends.

Holding these trends together with previous research, which narrates the intertwined revisions of the DSM (in general, and particularly the DSM-III) and WHO's International Classification of Disease (Horwitz, 2021), I argue for the possible presence of mimetic isomorphism between schools of psychiatric knowledge in the American Psychiatric Association and in European institutions. In other words, cross-national diagnostic similarities may speak to the power of each organization, that the cultures and values in one institution would be shaped using the model of the other (Appold, 2005). This is the case not because of "functional interdependence" but instead, possibly, because of each organization's efforts in "enhancing legitimacy and providing social validation" (Appold, 2005, p.21). As a result of the chronological proximity of these changes and the lack of explicit mentions of influence, it is difficult to know which institution held symbolic power, or if this is even an aspect of decision-making processes. Therefore, the inclusion of non-U.S. articles not only does not skew the larger corpus; it also provides evidence as to the international power of these conceptualizations and decisions.

Examining Arguments

Throughout this analysis, I will use the theories laid out by Stephen Toulmin on the structure of scientific arguments to better understand motivations for changes in the conceptualizations of grief (Toulmin, 2003). In his writings, Toulmin emphasizes the importance of attunement to the "micro-arguments" present in discourse as they play into larger claims (Toulmin, 2003, p.87). At their simplest, arguments consist of two stated components, data and conclusions, that are connected by implied warrants (Toulmin, 2003). Toulmin describes, "the data we cite if a claim is challenged depend on the warrants we are prepared to operate with in that field, and the warrants to which we commit ourselves are implicit in the particular steps from data to claims we are prepared to take and to admit" (Toulmin, 2003, p.93). Among many complexities, Toulmin notes that warrants often rest on underlying backings, or discipline- and situation-specific knowledges and claims, which may become the context of disagreement if an argument is challenged (Toulmin, 2003). In examining the connections between various components in arguments and explanations present in this corpus, I will

pay particular attention to the possible backings behind warrants, their implications, and what they reveal about the discipline.

Timeline Trends

A final guiding note is that, throughout the results and analysis, if there was not a clear year at which a specific trend began, the timepoint of 1985 was often used to allow for a chronological comparison. This was chosen both because it is a halfway point for this data and with the general assumption that it might take a few years for the disciplinary changes established in 1980's DSM-III to take hold among researchers/publications. As discussed, I made counting-based considerations around this timepoint aware of the relative-different number of articles published in each segment, and sought to compare relative density of ideas in each segment rather than counts of before/after. Moreover, in many cases it should be noted not only that trends are notable even while taking article density into account, but also that the increase in number of articles only supports many of the trends being argued.

Thread 1: Shifts toward a New Psychiatry

Over the course of the timeframe, language used to define grief, approaches taken to study it, and interventions recommended for its treatment all suggested a shift away from traditional theories and into new norms of psychiatry. Particular focus is paid in this section to the work of Freud and other psychoanalysts as the point of departure from which a new psychiatry was formed because these are generally considered to have been the dominant theories in the psy-disciplines mid-20th Century (Whooley, 2019). In discussing a new psychiatry, I am focusing on three key characteristics that appeared in this time and have since become commonplace among practices and conceptualizations: shifting the definition of grief, adapting new ideas of recovery, and moving away from broader psychoanalytic assumptions about grief. In this section, I will discuss the evidence for each aspect of this transition to a new psychiatry, the role that measurements played in this change, the alignment of these findings with other data, and the implications of this thread.

Defining Grievs

The first key theme suggestive of a new psychiatry is the change in content and models suggested by the data. While attitudes toward Freud and other significant psychoanalytic scholars and theories were consistently mixed throughout the timeline, subtler changes occurred which should be noted. As mentioned in the literature review, Freud distinguished mourning from pathology (melancholia) by the presence of a recognized loss and the absence of emotions of self-regard like guilt. He and other psychoanalytic scholars also used the language of mourning throughout references to grief and described symptoms such as hallucinations as expected in grief/mourning experiences.

There is evidence to suggest that each of these facets of mourning was challenged throughout the timeframe studied. First, within the definitions of grief, small but powerful edits were made. Of all symptoms referred to in definitions of normal grief, 'guilt' was most common, directly contradicting Freud's claim that guilt is a defining feature of pathology. Reference to guilt was consistent across the timeframe examined, suggesting that this definition-shift may have occurred in earlier years. Additionally, in the first few years of the timeframe, 'hallucinations' was present in definitions of normal grief, aligning with Freud's theories. Its absence in definitions after 1989 and presence in one 1995 definition of pathological grief suggest a change in perception of this symptom, and, with it, an added shifting away from formerly dominant psychoanalytic definitions.

Definitions of grief in 1995 brought with them a final notable symptom-difference in the addition of yearning to concepts of pathology. This term was key to attachment theories and present throughout conceptualizations of normal grief in the beginning of the timeframe. Evidence of this straying is supported by the increasing critiques of the lack of specificity or empiricism in attachment theory models.

These pieces of evidence, while granular, suggest a shifting of conceptualizations of normal and pathological grief in the departure from traditional modes of understanding.

Resolution

In addition to changes in definitions of grief, the evidence also suggests changes in definitions of recovery from grief. Freud emphasized grief as a process that was natural, experience and expression of which were shaped by context and culture (Freud, 1953). He wrote that grief ended

with the removal of libidinal bonds from the lost object, and that it did not follow any set course or timeline (Freud, 1953). In contrast, trends in multiple codes suggested an increasing emphasis on grief as something that reaches a resolution or that an individual can get over, as well as emphasis on this resolution as something that should be actively sought. Evidence for this idea was observed in the language of the effects of social support, the language of recovery, and the content analyses of ‘resolution’ and ‘unresolved.’ It is important that, in each of these codes, references to ‘resolution’ and ‘unresolved’ did not enter the discourse of grief with any consistency until 1985, suggesting the novelty of the conception that grief can be resolved in any definite way. Moreover, in seeking to articulate a backing connecting the claim that social support should be provided and the warrant that it facilitates resolution, it seems evident that the resolution of grief became something that could – or perhaps, should – be worked toward actively.

Adding to this idea that the resolution of grief ought to be worked toward was the trend suggesting an increase in the use of refining words for resolution (appropriate, successful) after 1990. These choices seem to suggest a narrowing of the definition of health, a higher bar set for attainment of recovery, or the possibility that there is no proper way to ‘successfully’ recover from grief. Together, these data suggest that grief was reconceptualized as an experience with a definite end that must be reached in a certain way. Inability to reach this end may merit diagnosis of pathology.

Intervention and Expertise

In addition to the meanings of grief and its ending, trends in this data provide evidence for significant departures from Freud’s key concepts that grief is a natural process, that it is not to be seen as pathology or interfered with, and that grief is “overcome after a certain lapse of time” (Freud, 1953, p.244). Departures came in both direct statements and in the very enactment of many of the studies.

There were only five articles, none published after 1986, that included statements on grief as a process that does not require treatment. The silencing of this notion is notable in itself. Additionally, one of the most referred to motivations for studying grief, particularly in later years, was the need to predict grief outcomes and identify early signs of pathological outcomes. If we consider Toulmin’s theories, the implied backings that link the act of examination with the warranted need to know about the (pathological) path of a grief response seem likely to entail belief that grief can be understood and,

possibly, that grief can be intervened upon to prevent pathology. These warrants and backings, even if assumed in their most conservative versions, contradict Freud's acceptance of the natural flow of grief and insistence that professionals not interfere.

Even more clearly supporting this assumption were studies rationalized by an explicitly stated motivation to intervene on the grief experience because of the suffering involved. This motivation exhibited a four-fold increase between the first and second half of the timeframe (i.e., at least doubled in density). Particularly when held together with the increasing notion that only those within the psy-disciplines should intervene on grief experiences and the progressive narrowing of definitions of 'normal' grief (both to be discussed more thoroughly below), this argument speaks powerfully to the development of new psychiatric norms of pathologization and intervention.

Moreover, when psychoanalytic theories and cautions against interfering with grief were removed, physiological symptoms were reconceptualized as (newly biomedical; Horwitz, 2021) psychological phenomena, and became objects of treatment rather than manifestations of loss-related processes. References throughout the data clarified the forms of expertise equipped to study or treat grief. As described, while early articles acknowledged the roles that leaders beyond the psy-disciplines, such as clergy or teachers, can or should play in supporting grieving individuals, later articles shifted to implied or explicit statements that only those trained within the psy-disciplines were equipped.

Relatedly, the data seemed to be increasingly silent on the roles that rituals or other practices of expression could play in the grief process, with the only mention of rituals after 1986 being a nod to their absence in the U.S. context. There was also, in a few instances, the implication that spaces of treatment within the psy-disciplines were to serve as a replacement for rituals or community spaces. This left the lack of culture/ritual unquestioned, thus silencing the processes of power and knowledge involved in fostering such a change. This trend, though assumed more in silences than substantial evidence, may be suggestive of an increasing denial of the possibility that grief be expressed in any space beyond that of psy-discipline expertise.

These trends combine to suggest that intervention by experts in the psy-disciplines came, over the course of the timeframe, to not only be important and disciplinarily exclusive, but also necessary or expected.

Implications and Role of Measures

Previous Literature. The trend in the shifting of definitions for grief is supported by previous research. Even as there are not descriptions of changes within the specific symptoms of grief, such as guilt, yearning, and hallucinations, these transitions, when taken as a whole, align with the broader changes that took place in psychiatry with the publication of DSM-III (Horwitz, 2021; Shorter, 2008). As described in the literature review, Robert Spitzer and the DSM-III Task Force were intentional to distance themselves from symbol-laden theories and toward a nosology of psychiatric diagnosis rooted in biomedical and psychological language (Horwitz, 2021; Whooley, 2019). It is crucial to remember that grief was not a diagnosis in the DSM until 2021. For this reason, the shifting of language here, and the larger redefinition of grief as an object of a new psychiatry, speaks powerfully to the creation of a specific range of possibility in which grief can become a diagnosable phenomenon, even with thirty years' separation.

Moreover, previous literature has discussed the development of a psy-discipline that encourages intervention on grief as beginning with the work of Lindemann, and the origin of the concept of 'grief work' as a task to be completed with the help of psy-discipline experts, stemming from reinventions of Freud's writing amid ego-psychology and psychodynamics (Granek, 2010; Whooley, 2019). Throughout the data, these arguments were supported by references to Freud and Lindemann as significant in the history of grief and by increasing emphasis on understanding and facilitating grief work. Moreover, there was little to no mention in previous literature of the concepts of resolution seen here, much less a resolution that must be 'successful,' 'complete,' or 'healthy.' The introduction of this concept is important in that it implements a(n increasingly narrow) mandatory finish line of sorts, straying far from Freud's acceptance of the natural path of grief.

Measures. The use and development of measures is intertwined with each of the components in this thread. First, the very existence of measures is, the data suggested, in large part due to the motivation to track and predict experiences of grief. The fact that the majority of measures

developed or used in this corpus made use of Likert scales, the most widely used psychometric devices (Sack, 2020), evidences that this movement was into an established set of expertise in the psy-disciplines. Moreover, as the tool for defining grief, the content of measures changed in this time to reflect new definitions of grief and, in this, to cement these constructs as objective (Merry, 2016). Measures also, as discussed in the data, were the tools by which the severity of a grief experience was understood, and thus the tools used to determine the relative pathology of an individual's grief, as well as the degree to which their resolution was 'complete.' Importantly, the data suggests that this new psychiatry required that the grief process – and, with it, measures – be understood and used only by psy-discipline experts.

The creation of quantitative measures was therefore a product of the changes incurred in this first thread insofar as it was motivated by new desires to track, predict, and delineate grief, even as it was also a tool used to instill these concepts in the discipline, to cement as objective new definitions and realm of expertise for grief.

A new psychiatry, in sum. In the creation of a new psychiatry, therefore, 1) grief is no longer accepted as a natural response to loss, 2) formerly expected behaviors and emotions are included in definitions of grief, 3) grief is an experience to be overcome with the assistance of expertise exclusively within the psy-disciplines, and 4) grief is not overcome until an individual has attained a benchmark of success as determined by the expertise or the measures they wield. Measures serve as a product of this new psychiatry and as a tool used to reify this reality.

Thread 2: Emphasis on Complexity and Multidimensionality

A second key thread evident in smaller trends in the data was that increasing emphasis was placed on multidimensional understandings of grief. This was evident in the critiques of previous research, in motivations for studies conducted in the corpus, and in the emphasis placed on quantitative data. In this section, as in the previous, I will explore the evidence for this thread before discussing its larger implications and the roles of measures. It must be noted that there is some degree of overlap between these threads, and thus that trends used in support of other claims may also support this, and vice versa.

Critiquing Previous Research

Throughout the articles, critiques of previous research spoke powerfully to the values of the changing field. The most striking trend among these was the consistent emphasis on the simplicity or overgeneralizations present in past studies, even as references to grief's complexity remained reasonably consistent. In discussions of models and theories for grief, authors after 1984 tended to point out lack of specificity to factors such time since loss or demographic or situational differences. Additional critiques discussed incorrect assumptions of a linearity or simplicity in grief. Similarly, examinations of previous literature tended to highlight the 'unsystematic' nature of study or the inadequate acknowledgement of grief's multidimensionality. Although there were no trends in the number of dimensions in developed/used measures for grief (Table 4), the same critiques were present for measures, calling for increased specificity to various dimensions, types of loss, and most-recently-supported models. These evaluations increased in consistency over time and were particularly present in the second half of the timeframe.

Thinking with Toulmin, if the data in these arguments is the preexisting model, method, or measure, and the claim is a lack of orientation to nuance, then the warrant and backing seem to rest on an (increasing) standard for necessary complexity of conceptualization. This supports the notion that grief was increasingly created as a discrete phenomenon within the psy-disciplines. The fact that this claim comes in the form of a critique of the past also affirms previous arguments on the language of scientific expertise and the constructed perception of linear progress (Kuhn, 1996).

In holding these critiques as representative of the larger discourse, it is important to remember that, though by far the most consistent and common, they were not the only arguments present. Moreover, as Kuhn suggests, the views of previous research were likely influenced by the movements 'forward' being taken at that time, and thus shaded by the voices of prominent scientists in the field (Kuhn, 1996). This is important to note as a possible weakness in this claim. Nonetheless, because of the communal nature of science and the construction of scientific progress, I argue that it does not altogether defeat the claim – if voices were listened to more than others, that too likely represents the dominant views of the moment. The present situation of grief studies, in which wholly decontextualized symptom network maps are accepted and advocated for as platforms for

understanding grief, speaks also to the possibilities created by these emphases, and thus the importance of acknowledging it.

This trend supports the notion that grief studies saw in itself the need for scientific progress away from the inadequate methods of the past, implying the perceived superiority of specificity and dynamic understandings.

Impulses for Further Study

Closely related to the critiques of previous research in this thread were the changes in content and motivations enacted in the studies themselves. Reflecting their views of the past, many researchers developed research questions with the aims of creating multidimensional models of grief. One common manifestation of this goal was the creation of timelines for separate symptom experiences, with the aims of mapping various peaks and troughs for each symptom according to a population's 'normal' grief 'progress.' (Note here the dependence of these constructs on the expectations set into being in the previous thread.) In fact, among all of the studies in the corpus, a slight majority (51.4%) had the primary goal of correlating the severity or chronicity of grief with other variables or understanding the path of individual grief symptoms. The trends in Figure 4 (Appendix 1) suggest that this impulse increased over time – and the modern existence of network analyses confirms the continuing role of these impulses. This priority is also supported by the increased orientation toward the expected (or 'normal') longevity of grief, a factor that was not considered in this corpus until 1985 and was increasingly taken as important to discover after.

The very act of separating grief into its various symptom components, from which to draw timeline-predictions, also affirms the trends in previous threads and sub-threads. This dissection might be seen as a continued straying from acceptance of grief as a natural (socio-culturally determined) phenomenon, including the increasing conceptualizations of grief as psychological object and as object of scientific expertise.

Moreover, three articles described their studies as related to a call for research into variables predictive of grief outcome made by the Institute of Medicine's Committee for the Study of Health Consequences of the Stress of Bereavement. While not referenced frequently, this national call – and the very existence of a Committee for the Study of Health Consequences of the Stress of

Bereavement, much less the 312-page report they published on “reactions, consequences, and care” (Osterweis et al., 1984) – provides strong evidence supporting the idea that multidimensional prediction of grief outcomes was an increasing priority in this time.

Thus, throughout, and particularly in the latter half of the timeframe, emphasis was placed on conceptualizing grief through its various symptom components, revealing priorities of understanding grief as multidimensional and predicting it as such.

Quantification

A third trend in support of the overall thread of an increasingly multidimensional understanding of grief was the emphasis on quantitative data. This was seen throughout critiques of previous research, rationalizations for decisions, and hopes for future work.

Interestingly intertwined with calls for a more complex or multidimensional understanding of grief were calls for methods that would be less strongly influenced by individual differences. Support of this trend was particularly evident in evaluations of previous studies that emphasized their small sample sizes, the biases introduced by interview or other forms of qualitative data, and the aforementioned ‘unsystematic’ nature of the research. Moreover, these evaluative statements were frequently used to introduce larger scale quantitative studies or the development of quantitative measurements. The implied backing behind these recommended or presented quantitative approaches may be the assumption that quantitative data provides more standardization, is less prone to bias because of its decontextualized nature, or generally allows for a more accurate understanding of the grief process.

As mentioned in the results, a striking trend appeared in the last 6 years of the timeframe: while the prevalence of studies using interview methods did not decrease significantly, the studies that used these methods began to include thorough rationalizations of this choice. These explanations seem to suggest an anticipation of criticisms of reliance on qualitative sources. If rationalizations of choice were merited by the culture of the psy-disciplines, it seems that quantitative data, by the late 1980’s, might have become the expectation or ideal within psy-discipline research. This idea supports Merry’s (2016) arguments on the increasing seductiveness of quantitative data’s perceived objectivity, particularly in the context of a newly-scientific psychiatry (argued in thread 1).

Intertwined with this evidence, the increasing number of studies to either develop or use measures also affirms the idea of an emphasis on quantitative data. As mentioned, motivations for the development of measures often included the very lack of measures for grief (“unfortunately, the construct of grief has never been...;” Faschingbauer et al., 1977), as well as the simplicity of previously constructed measures. The processes of measure development and quantitative data collection were presented throughout the corpus as necessary, expected, or as the inevitable next step, the only method through which an ‘empirical’ and adequately multidimensional understanding of grief could be developed.

The evidence in this trend supports the notion of parallel and related urges to quantify the grief experience and to understand it at increasingly complex levels (particularly for prediction and intervention).

Implications and Role of Measures

Previous Literature. The need to examine and understand grief in an increasingly multifaceted way, and the quantitative models used to address this need, support claims about the broader cultures of science and psychiatry that developed in this era. As described in the literature review, the past few centuries have brought with them general emphases on precision, efficiency, and understanding (Hacking, 1990; Granek, 2010) as well on a newly seductive quantification (Merry, 2016). Emphases on precision, Hacking argues, were closely related to the “imperialism of probability” and the need to predict – toward controlling – the unknown (Hacking, 1990, p.5). These cultures are thought to have shaped the psy-disciplines most directly in the last quarter of the 20th century (Horwitz, 2021; Whooley, 2016; Granek, 2010), claims supported by the emphasis on quantification and prediction present in the data. Further, the refinement of technologies of care, which encouraged specificity of conceptualizations of grief, aligns both with this general emphasis on precision/prediction and with the increasing attunement toward smaller symptoms and risks produced by psychopharmaceutical research and marketing (Dumit, 2012). The first thread is closely related with this (and with previous narratives of grief’s history; Granek 2010), as the development of multidimensional models is closely related to the perceived need to predict grief outcomes and intervene on the grief experience.

While affirmed by observations of the broader cultural and disciplinary trends, this thread's argument of an increasing emphasis on multidimensionality is not thoroughly discussed in the literature. It is important to acknowledge this emphasis from today's context, primarily as it laid the groundwork on which examinations of grief can take the decontextualized multimodal and neuroscientific forms of much of modern discourse. The very act of mapping the severities of various symptoms, or of correlating neural substrate functionality with grief experiences, would not have come to be without early reorientations to grief as a multidimensional object. Furthermore, this factor is important for a similar reason as the first thread: even as psychiatry was undergoing its 'neo Kraepelinian' revolution (Whooley, 2019), the phenomenon of grief, not yet object of a psychiatric diagnosis, was also being reconceptualized as a collection of symptoms. In other words, the application of psychiatry's new lenses and tools of investigation for grief both speaks to the ways in which grief was increasingly medicalized and creates a path of possibility by which grief can attain official diagnostic categorization in 2021.

Measures. As described, measures played multiple critical roles in this thread of grief as multidimensional object. Measures were an object of critique for lack of multidimensionality and their creation and use was rationalized by a desire for more substantial, complex, 'empirical,' or generally quantitative data. Throughout multiple studies, measures were developed based on theories of multidimensionality and used to gather information about grief as a multidimensional object even as they were simultaneously used as tools to prove these same theories, often through methods of factor analysis. Therefore, this thread, significant in the medicalization of grief and the creation of the possibility in which grief can be a diagnosis, is inextricably intertwined with the process of operationalization.

A multidimensional grief, in sum. In this time, reflective of priorities in scientific methods and resulting from grief's examination in a new psychiatry, grief was reconceptualized as a multidimensional object. Evaluations of previous research and calls for present and future research were based in the necessity of a more full understanding of the various components of grief, the chronicity of each over a 'normal' course, and their relationships with each other, with individual factors, and with the severity of overall grief experience. This emphasis was likely encouraged by a

larger cultural emphasis on understanding and predicting complexity through quantitative research, even as it seems to have resulted in the development of multidimensional measures. The measures themselves exhibited tautologies in both shaping and being shaped by theories of dimensionality, as will be discussed further later.

Thread 3: An Expanding Pathology

The final key thread suggested by trends in the data builds off of and adds to two aspects of the first thread: that the definition of grief changed in this era, and that theory departed from Freud's, creating a grief that could be pathological. In this third thread, I argue that the data suggest an increasing pathologization of grief, both in expanding the definitions of pathological grief and in suggesting that grief itself might be a pathological experience. This thread is supported by three smaller trends: the creation of a categorical 'normal' in grief, the opening of definitions for ab/normal grief, and the shifting meaning of health. As with previous threads, these sub-trends are intertwined with one another, as well as with ideas already presented.

Creating Normal

As mentioned in the results, whereas the word 'normal' was used in many early instances as an adjective, implying very broadly that certain reactions were expected in certain sociocultural contexts, its use in later years transitioned to that of a discrete category. 'Normal grief' became a psych-discipline phenomenon in itself, with a clear definition, and experiences beyond this definition were presumed to be pathological. For example, while the introduction of the first measure, the TIG, posited normalcy purely in statistical terms ("a score greater than 2 standard deviations above the normative sample mean;" Faschingbauer et al., 1977, p.697), this was the only study to use these concepts. Later papers presented ab/normal grief only in the language of symptoms and described category identification as a process of discovering discrete entities rather than identifying population trend-based benchmarks. While it must be reiterated that there were a few exceptions to some of these trends, the evidence was substantial enough to suggest that this reconceptualization became the dominant thought.

A few additional trends support the idea of a category-creation for normal grief. For example, the decrease in references to grief as a construct (and absence of these references after 1988) suggests the increasing acceptance of ‘grief,’ ‘normal grief,’ and ‘pathological grief’ as discrete entities. Further, in addition to the aforementioned opening up of grief into an experience that can exhibit pathology, descriptions of increasingly discrete forms of pathological grief appeared over the course of the timeframe. Most notable among these pathologies was the creation and speedy institutionalization of ‘complicated grief’ as another discrete category in the early 1990’s. The creation of these categories of non-normal grief support an intentional delineating of normalcy. Finally, while depression was referred to in a variety of ways throughout the corpus, one notable trend was the increasing drive to separate the category of major depression from that of grief or complicated grief and to ensure that operationalized definitions for depression and grief were mutually exclusive. This affirms the suggestion that grief was conceptualized as a discrete psychological object. Importantly, operationalized definitions and measures were the tools by which boundaries were drawn for each phenomenon.

The data, in sum, support the idea that ‘normal’ grief was created as a discrete phenomenon in this time, and that variations of grief’s exhibition were increasingly conceptualized categorically.

Delineating Pathology

Even as normal grief was being reified, the definitions of pathological grief changed significantly in this time period. Though notable variety existed in both the content of definitions and the modes of explanation for pathological grief, a few important trends arose which suggest an increasing pathologization of the overall grief experience.

First, in examining the results of the content analysis for definitions of normal grief in comparison to those of pathological grief, there is notable overlap. Grounding word trends in the larger context of definitions and discourse provides evidence to suggest that there was some degree of transfer over time, with traits of formerly normal grief considered pathological. For example, the symptom of crying was added to some definitions of pathological grief after 1991, which is striking in that crying was accepted as an expected reaction to loss for decades (if not millennia). Moreover, as mentioned in thread 1, ‘yearning,’ previously a key concept in attachment theory’s definition of grief,

was added to multiple definitions of pathological grief in 1995. While sparse, these examples are striking and suggest significant changes in understandings of grief.

Second, this trend is supported by another that was subtler and less clear, but nonetheless important. As described in the results, discussions of the treatment of grief acquired a certain vagueness in later years, and it became unclear whether authors were recommending the treatment of only pathological grief, or that of all grief (or altogether presenting grief as a pathological experience). One example of this implication came in 1991, when Sable wrote that “the loss of a spouse is widely recognized as an extremely painful and distressing experience, *associated with risk of psychological and physical distress*” (Sable, 1991, p.129, italics mine). Throughout this article, ‘distress’ was described not as an expected or normal experience in the wake of a significant loss, but rather as something to be “mitigate[d]” (Sable, 1991, p.139). This seems to suggest that distress is something which should be avoided, prevented, or treated in clinical spaces. This example is only one representation of the trend in ambiguity, yet I argue that it speaks powerfully to the pathologization of grief itself, particularly in the early 1990’s.

There is evidence, therefore, suggesting that the definition of pathological grief (upon its introduction as a possibility into the psy-disciplines, as described in Thread 1) shifted increasingly to include facets of formerly non-pathological grief, and possibly the entirety of the grief experience.

Redefining Health

The final aspect of this thread is a set of trends suggesting a changing conceptualization of health. References to health most frequently came in discussions of recovery from grief. While the first thread evidenced an increased emphasis on resolution, and on ‘successful’ or ‘completed’ resolution, which certainly relate to this theme, I hope here to explore additional aspects of health as defined throughout the corpus.

Throughout the definitions of recovery and restoration of health, later years brought with them an increase in instances of the words ‘function’ and ‘coping,’ as well in emphasis on symptoms related to functionality. These suggest a reconceptualization of health oriented toward baseline ability, as opposed to emotion or individual standards. For example, while early definitions of grief, echoing Lindemann (1944), cited physiological symptoms along the lines of breathing difficulties and

pain in the areas of body where the lost person experienced pain, later definitions were far less likely to cite any of these symptoms, and instead placed more emphasis on symptoms such as loss of appetite and inability to sleep. Adding to this, beginning in the 1990's, descriptions of recovery from grief were more likely to entail restoration of previous levels of function, as opposed to finding new levels or norms.

Moreover, while some early articles rationalized the act of investigating grief on account of heightened long-term morbidity and mortality rates, later articles were far less likely to cite these statistics, and instead described the pain of grief or correlated psychological diagnoses as the notable long-term risks. This shift seems suggestive of a transition of psy-discipline and cultural values from attunement to physiological health and illness to that of emotional pain and illness. It may be related to observations in the previous literature on the formation of the psy-disciplines as a more distinct source of expertise, such that stakes meriting intervention would also be within the realm of psy-experiences (Horwitz, 2021; Whooley, 2019).

Overall, two key facets of the meaning of health, particularly as they relate to the stakes of grief, changed in this era: reflecting the power of psy-discipline expertise, the importance of studying grief was grounded in its psychological risks, and, reflecting neoliberal prioritizations, discomfort in and recovery from grief increasingly aligned with ability to productively function.

Implications and Role of Measures

Previous Literature. Many of the trends in this section connect with those established by previous research. First, while authors such as Leeat Granek have examined and articulated the ways in which grief has increasingly become an experience that can be pathological (Granek, 2010; Bandini, 2015), aligning with the arguments made here, literature has not discussed the shifting meanings of 'normal' with reference to grief. The only related concept explored in the literature review was Dumit's general observation that 'health' came to be seen as inaccessible or as a myth in the age of pharmaceutical technologies (Dumit, 2012). If these ideas are connected, then the creation of a normal (i.e., healthy) grief and narrowing of that normalcy might reflect its increasing inaccessibility, and thus the ways that psychopharmaceutical marketing and risk-based research and treatment incentivized the pathologization of grief. An overall lack of mentions of medical

motivations or related implied backings makes this claim difficult to defend. Regardless, I argue that attunement to the concept of ‘normal’ grief, and particularly to its category-formation, is important in that it allows us to see the intentional decisions made to create the possibility of a pathological grief.

Moreover, the shifts within definitions of normal and pathological grief are also supported by previous research on the cultural and psy-discipline shifts that occurred in this timeframe, even while not necessarily specific to grief. The transition to a health defined by ability to productively function may be, as discussed in the literature review, reflective of cultural orientation toward neoliberal ideals (Ehrenberg, 2010; Robbins, 2014). Similarly, the possibility of all grief being pathological is supported by the aforementioned increased pathologization of physical and emotional pain, that its risk would be enough to merit investigation and its experience treatment (Culley, 2014; Dumit, 2012; Graham, 2011). Dumit’s arguments on the influence of pharmaceutical development also align with the data’s orientation toward “mass health,” or the need to discover and treat increasingly smaller risks of pain/illness (Dumit, 2012, p.8). While much of this literature concerns symptoms and illnesses in general, and are not specific to grief, it is helpful to recognize the pathologization of grief within larger medico-societal impulses.

Moreover, these changes align with a recent argument by psychologist Nick Haslam and colleagues, who proposed “concept creep” as a lens through which to understand “psychiatrization” (Haslam, Tse, & Deyne, 2021). They define concept creep as “the gradual expansion of the meaning of harm-related concepts,” such that they include increasingly less-specific and less-severe experiences (Haslam et al., 2021). The authors argued that this idea can be used to nuance understandings of psychiatrization, or the general medicalization of experiences into psychiatric diagnoses (Haslam et al., 2021). He points out the professional powers at stake in these processes, as has been discussed throughout this project (Haslam et al., 2021). This intertwining of processes is helpful in understanding how experiences of grief have, in general, not changed, but instead have been psychiatrized, even as the delineation of normalcy around them has crept, such that ‘pathological grief’ contains decreasingly severe and specific symptoms (Haslam, 2021).

Measures. The creation and use of operationalized definitions and quantitative measures is closely intertwined with the changes at work in this thread. First, the rationalization for creating

measures frequently involved the capability of diagnosing pathological grief experiences, even as many articles also described measures as tools by which to investigate and discover the boundaries between pathological and normal grief. This suggests that measures play a similar role in defining pathology as was seen in their being used to prove and apply theories of multidimensionality.

Moreover, it is likely not incidental that ‘normal’ grief became a distinct category in the same years that grief was operationalized. In thinking with arguments like Merry’s, it seems that the process of scientifically defining and systematically quantifying the grief experience may have introduced “the aura of objective truth and scientific authority” (Merry, 2016, p.1) necessary to successfully decontextualize and create the ‘scientific’ category of normalcy. This, in turn, seems to have opened the door to further medicalization and creeping, thus creating the possibility for the eventual pathologization of grief itself.

A pathologized grief, in sum. The evidence in this thread suggests that, in this timeframe, grief was not only introduced into the realm of the psy-disciplines, but that ‘normal’ and ‘pathological’ grief were created as discrete categories, and that the category for ‘pathological’ increasingly expanded. Measures, as the tool of diagnosis and of construct-confirmation, played a significant role in this process.

Implications

In bringing together each of the more granular trends throughout the data, I have argued that three key threads arise that describe the changes in this psy-discipline discourse about grief: discussions of grief took on the characteristics of a newly medical, expertise-, and intervention- driven psychiatry, increasing emphasis was placed on developing multidimensional models to allow for the prediction and treatment of grief, and definitions of pathological grief were created as categories and shifted to include formerly non-pathological experiences. Put differently, in this era, grief became a discrete object of psy-discipline expertise, an experience that could exhibit (if not was fully) pathology, and one which had to be examined, tracked, and treated. Operationalization played a significant role in these changes.

This section will explore implications of these conclusions by drawing on theories and arguments put forth in previous research. First, I will explore notable trends in the data as they speak to some of the key themes brought forth in previous research relating to the cultural power at work in shaping grief. Second, I will reexamine Foucault's concept of the clinical gaze as it informs our understanding of the implications of the development of grief as an at-times-pathologized object of psy-discipline expertise. Finally, I will explore the concepts related to operationalization, including data inertia, experimenter's regress, and dynamic nominalism, as they allow us to better see the mechanics of operationalization's role.

Cultural Interchanges

Even as I presented an overview of the arguments and gaps in the literature in discussions of each key theme, I hope here to begin building on this work. I will explore trends in the results as they elucidate or challenge claims on the role of neoliberalism in changing cultural acceptance of grief and death, on the possible motivation to control uncertainty, and on implications of these cultural interchanges.

Neoliberalism and Cultural Taboos. Throughout the data, references to the larger cultural moment spoke to the changes – described and real – that set the stage for the medicalization and operationalization of grief, and these references are helpful in understanding the implications of trends. Notably, throughout the corpus, the U.S. culture was described as lacking death-related customs or tabooing death, mourning rituals were attributed to past eras or non-U.S. cultures, and there were no mentions of rituals, or of the role of clergy/religion in grief, after 1986. While not present in every article, the consistency of this type of reference suggests its dominance within the discourse. These trends are important in that they align clearly with the aforementioned patterns described by Laqueur, wherein death is described as taboo when, in actuality, the opposite is the case. “Narratives of disappearance,” as Laqueur terms them (Laqueur, 2015, p.13), reflect neoliberalism's shaping of culture, such that medical technological advances antagonized death (for some) and normalized methods of universal comparison, deeming proper only certain modes of expression.

I argue that the insistence on a dearth of cultural modes of healing or understanding amid grief is powerful in the intertwining histories of medicalization and operationalization. First, the psy-

disciplines, throughout the corpus, assert with few exceptions (regardless of the truth) that there remain no fit spaces for conceptualizing grief beyond that of the clinic. Thinking with Toulmin, if the data in this argument is a stated cultural need for spaces that consider grief, and the claim is an enactment of research within the psy-disciplines, the implied warrant and backing are that the pys are the sole disciplines capable of holding knowledge-power over grief. These arguments are powerful both because of the knowledge they create and because of the power over knowledge production that they imply.

Further, Espeland and Stevens posit that claims to a phenomenon's incommensurability (i.e., inability to be operationalized in a measurement) occur most frequently when that phenomenon is in the "borderlands" of multiple disciplines, where mechanisms and meanings of valuation conflict (Espeland & Stevens, 1998, p.332). I argue that the data support this claim in the instance of grief, an experience that was once held between culture, religion, and the social sciences (Granek, 2010). In asserting knowledge-power over grief, the psy-disciplines moved grief away from the borderlands, making null any claim of grief's incommensurability. This ensured not only that grief was considered the object of psy-discipline expertise alone, but also that it was deemed quantitatively operationalizable.

In sum, by narrating the disappearance of cultural and discursive acceptance of death, despite contradicting reality, the text of this corpus is doing productive work, creating the possibility for psy-discipline expertise over – and thus medicalization of – grief and, in doing so, creating the possibility for its operationalization.

Controlling Uncertainty. Another claim presented in the literature review was Ian Hacking's narrative of the "imperialism of probability" motivated by the need to control uncertainty (Hacking, 1990, p.5). There were definite trends supporting an imperialism of quantification throughout the data, including the aforementioned emphasis on creating measures and using quantitative methods, as well as the lack of mentions of grief as beyond understanding after 1986. The data also suggest emphases on controlling uncertainty, as key motivations for creating measures were quantifying grief, testing models for grief, and correlating the grief experience with other experiences. These findings were used to control uncertainty by creating predictive models and

writing with orientation toward facilitating grief work. In these ways, Hacking's claims on the imperialism of probability seem to be supported by the data.

However, I argue that both previous literature and the data encourage nuance in these connections, that the application of Hacking's claims in this space is reliant on the changes incurred in the cultural claiming/medicalization of grief established in the previous section. As Granek traces, grief was, for much of history, an experience held, guided, and understood by local factors (Granek, 2010; Granek, 2012). Freud, similarly, described grief not as unknown, but rather as a natural and expected process of libidinal detachment (Freud, 1953). Within the data, language of these concepts was seen most clearly in early acceptance of Freudian theories and attachment models, and in early use of 'normal' as an adjective, rather than a category, for grief. In this way, I argue, the data and literature suggest that, when held at least partially in spaces beyond the psy-discipline of a new psychiatry, grief's certainty and predictability were not in question. This is not to say that grief was a fully understood or predictable experience, but rather that, with the tools and within contexts of these spaces, theories, and models, there was little motive to create new knowledge about grief. In the time before its full medicalization, the disciplines and cultural areas that considered grief did not consider it to be of pressing uncertainty.

It was not until the psy-disciplines had more fully claimed the experience, narratively silencing other disciplines and recreating grief as a medical object to be understood in clinical spaces and in the language of symptoms, stages, and diagnoses, that the acceptance of grief within other contexts and models was deemed 'unsystematic' or 'unempirical;' only then was grief in need of discovery. Holding this together with the claim of the previous section, I argue that the very shift into singular-disciplinarity that created grief as a commensurable object also brought with it a realm of uncertainty to be explored. Thus medicalization created motivation for operationalization.

In this way, though it seems that Hacking's claims on the necessity of taming chance and controlling uncertainty apply clearly to medicalized grief (Hacking, 1990), I argue that this concept must be considered with nuance, as the idea of uncertainty was itself created in the process of medicalization.

Colonial Implications. As mentioned in the discussion of neoliberal universalization and in the literature review, the assertions of knowledge/power over grief in this time, despite changing conceptualizations of grief for all, did not impact all equally. While all grief became a medical experience, the operationalized definitions for normal grief were formed, as described, primarily using previous literature, previous models, and studies conducted among populations of frequently unspecified identities. For example, in this corpus, only three studies described the race of their participants, and each presented the non-White participants as otherized or as aberrations to norms. Further, as discussed, the most frequently cited authors were all citizens of a European country, some with partial U.S. citizenship. Therefore, the methods used to produce knowledge, in relying on specific sources of previous knowledge or on limited samples, inherently limited conceptualizations of grief. This data supports the claims made by Granek and Peleg-Sagy that the psy-disciplines, in presenting research on grief, tend to conceal possible bias in their sample composition by presenting no racial-demographic information (Granek & Peleg-Sagy, 2015). This, together with previous research on sampling trends in psy-discipline research, suggest that the definitions of grief produced in this time likely reflect educated and upper-class individuals who identify as White (Granek & Peleg-Sagy, 2015; Gaines, 1992).

This is important for many reasons. First, in the two studies that mentioned distribution of operationalized definitions in languages other than English, there was only acknowledgement of the inherent limitation of these scales in one article. Measures were not distributed among non-English speakers using processes of refinement to adjust symbolic and cultural facets of grief, nor were they presented as measuring contextualized grief. Instead, in these two instances, the measures were translated and distributed to measure ‘grief.’ Second, as this data has shown, operationalized definitions for grief, distributed via measures, were used to construct definitions of normal and pathological grief. The data suggest that there was a shift away from statistical definitions of normalcy (e.g., two standard deviations above the mean of a given population) in the move toward a new psychiatry, and normalcy was taken as a discrete category regardless of sample trends. This precluded the possibility of contextualization, particularly among less educated, non-White, not-culturally-(neoliberal)-‘American,’ and/or lower socioeconomic groups. Further, the distribution and

application of measures, taken as objective on account of quantification's seductiveness (Merry, 2016), creates inherently limited conceptualizations of normal grief among experts and the general public alike.

These trends suggest that modern grief studies – like modern research on many phenomena – is built on theories and data gathered among populations of privilege and societal 'dominance' (Gaines, 1992; Granek & Peleg-Sagy, 2015). The definition of pathological grief in the DSM-5-TR, in being shaped by research deemed objective because of operationalization, has the potential to pathologize any aberration from the norm. This is particularly impactful given previous research establishing vast variance in experiences and expressions of grief across idioms, cultures, and contexts (Rosenblatt, 2017; Granek & Peleg-Sagy, 2015; Rabins, 2019) and given the aforementioned tabooing of grief over losses not seen as valuable. When humans grieve lives deemed "bare" (Bishop, 2011, p.11; Agamben, 1985; in the U.S., I argue that this includes losses of non-White individuals, victims of state violence, and members of minoritized communities, among others) or express emotions in ways that stray from the socially, economically, racially, or culturally 'dominant' norm, they can be diagnosed with pathology.

Rather than receiving care in community, they might be prescribed expensive, time-consuming, or questionably-effective treatments (Stegenga, 2018) or subjected to stigma and exclusion (Bandini, 2015), implications of which will be discussed more in the following sections. This is not to say that pathologization and unneeded medical treatment is always the case for individuals who fall into non- 'dominant' categories, nor is it to suggest that individuals who are White, educated, or of higher socioeconomic status are free from pathologization. I also do not mean to claim that medical treatment is always harmful. Rather, I argue that it is critical we acknowledge that the data reveals significant limitations built into our conceptualizations of grief, and that this is particularly important when using these conceptualization as universal tools of knowledge-production, diagnosis, and distribution in the form of operationalized measures.

Object of the Clinical Gaze

Continuing to build on the implications of trends suggested in the data, the next sections will explore a number of previously proposed theories on knowledge, power, quantification, and category

creation as they fit and inform this study's findings. First, as discussed in the literature review, Foucault narrated the development of a clinical gaze in the 18th Century that could only be wielded by medical expertise, had exclusive powers of observation, was "always receptive to the deviant," and was necessarily oriented toward predictions and risks – "it was calculating" (Foucault, 1994, p.89). While this development far predates the era of focus in this project, I think that the narrative aligns closely with changes undertaken in the psy-disciplines as they sought the status of biomedicine (Whooley, 2019).

Diagnosis and Prediction. In taking grief on as an object of newly medical psy-disciplines, the work of the clinical gaze is evident in the 1975-1995 discourse. Foucault described the development of the clinical gaze as one which shaped the very conceptualizations of disease into a calculable set of "signs and symptoms" perceivable and interpretable by medical expertise (Foucault, 1994, p.91). In this process, Foucault argued, symptoms gained new meanings in discreteness, such that "there is no longer a pathological essence beyond the symptoms" (Foucault, 1994, p.91). This aligns with the trends in the data, as grief was reduced into discrete symptoms as it became the object of a psy-discipline seeking to be medical. We see this at work in the way that psychoanalytic theories, which allowed for explanations of experiences, were stripped away, in the reification of 'normal' and 'pathological' grief, in the increasing orientation toward risks (Dumit, 2012) and less-intense symptoms, and in the ways that experiences were increasingly understood in the terms of psychological phenomena.

The gaze is one not only of knowing, but, in the context of grief studies, it became one of predicting and of surveilling. Following Foucault, the introduction of grief as a medical object inherently introduced the need to calculate (Foucault, 1994), which we can see at work in trends toward an increasingly dissected network of symptoms forming a predictable and multidimensional model for grief. Moreover, the two excerpts cited in the results on Domains of Expertise powerfully evidence the enactment of this calculating gaze in a biopolitical pointing-outward. The excerpts urged that "support programs be directed to all segments of the population" and that education programs be implemented to notify all bereaved of treatment within the psy-disciplines.

While mentions like this only began in the later years of the study, and were not frequent, the presence of any evidence of these actions regarding the surveillance of grief is particularly notable in that grief was not yet officially a pathology. Further, previous research suggests that these excerpts are representative of the beginning of an era of surveillance, and that the primary tool for projecting this gaze onto the populous was the quantitative measure. As the literature review described, the psy-disciplines in the U.S. were oriented toward observing risks of illness in the general population after 1909, when Freud first introduced the concept that all individuals could exhibit pathology (Granek, 2010). Within grief studies, this grew into arguments such as that of Ronald Pies, that professionals must distribute scales into the public in order that they identify instances of pathology not recognized or understood by the individuals experiencing them (Pies, 2013). Further examples in previous research affirm the power of the changes evidenced in the data in creating the possibility for the clinical gaze to surveil negative mood. For example, Horwitz & Wakefield present data on the mass-distribution of depression scales across general practice clinics and entire cities (Horwitz & Wakefield, 2007, pp.144-146). Dumit describes the implementation of awareness campaigns and information/inventory mass-distribution associated with pharmaceutical (including antidepressant) marketing (Dumit, 2012). Other studies evidence the institutionalization of surveillance via scale distribution among the general public in many other psychiatric diagnoses, including generalized anxiety disorder, general distress, and post-traumatic stress disorder (Horwitz & Wakefield, 2012). Many of these large-scale studies of the public were initiated in the last decades of the 20th Century, thus using the tools and methods established in the wake of DSM-III's publication (Horwitz & Wakefield, 2012).

The evidence in this data of grief's increasing role as the object of epidemiological studies is therefore significant in that it suggests the psy-discipline's early assertion over observing and calculating the experience. The possibilities of grief's narrow psy-discipline articulation, diagnosis, and claim at exclusive expertise over grief (Pies, 2013) were created by decisions implementing the clinical gaze between 1975 and 1995.

Intervention. An additional implication of the development of the clinical gaze lies in the exclusivity of expertise it constructs. As discussed in the second thread, grief was not only introduced

as an experience necessitating intervention; it was increasingly conceived of as an object on which only psy-discipline experts could intervene. Even as this paper is more concerned with the process of quantifying and diagnosing grief than with the treatment that follows diagnosis, it is important to emphasize the connection between the two: naming grief as a pathology/pathologizable experience and as the object of clinical expertise served to both open individuals to the methods of psychiatric intervention and deny them of cultural and communal modes of healing. As such, the possibility of modernity's grief that merits the prescription of a psychopharmaceutical intervention³ (Bui, Nadal-Vicens, & Simon, 2012) was created in this moment of operationalization and medicalization, and the implications of this creation must not be overlooked.

While not explored thoroughly in the discourse of focus (“antidepressants” only had 7 mentions in the corpus), we must not forget the role of psychopharmaceuticals in a messy and profit-driven intertwining of insurance, diagnostic, and marketing institutions (Horwitz, 2021; Healy, 1999; Dumit, 2012). Some scholars trace the expansion of diagnoses and the pathologization of pain to market incentives in illusory “magic bullets” (Stegenga, 2018, p.61; Healy, 1999; Culley, 2014; Graham, 2011). Moreover, philosopher of science Jacob Stegenga, in laying out a systematic analysis of the research and development practices involved in medical interventions, argues that modern (Global North) modes of treatment are overly-reliant on largely inadequately-proven interventions that have the potential to be harmful (Stegenga, 2018). Risk of harm is particularly acute because, as both Stegenga and Dumit describe, there is a notable lack of funding into research on processes of ceasing medication, meaning diagnoses are increasingly understood as chronic and interventions that may not be wholly helpful, and may in fact be harmful, are accepted as “lifelong treatments, drugs for life” (Dumit, 2012, p.6; Stegenga, 2018).

It is particularly important to pay attention to the role of measures in acknowledging the power of an overly-interventionist clinical gaze. As established in the data, researchers, while constructing scales that are used in clinical spaces, placed the duty of exploring individual differences,

³ Notably, this study on “pharmacological approaches to the treatment of complicated grief” was published 7 years before pathological forms of grief were added to the ICD, and 10 years before they were added to the DSM (Bui et al., 2012, p.149).

contextual meanings, and personal experiences among patients on clinical professionals. Moreover, previous research has shown that, in the modern U.S., there have been significant increases in the prescription of mood-disorder-focused psychopharmaceuticals by “office-based physicians” (Horwitz, 2021, p.102). Because of institutional time- and financial- pressures placed on many general practitioners and psychiatrists, there is rarely possibility for exploring individual-based differences in personality, cultural understanding, or personal expression of grief, and abbreviated measures are often used instead to guide diagnosis and prescription (Rose, 2003; Horwitz, 2021; Dumit, 2012). Therefore, the transfer of measures and medical conceptualizations of grief between research and clinical spaces, because of the efficient, burdened, and interventionist nature of U.S. (and Global North) medical systems, contributes to the outward-gazing distribution of diagnoses and psychopharmaceuticals based on decontextualized and colonially-constructed definitions (Rose, 2003; Dumit, 2012; Stegenga, 2018).

Acknowledging the over-prescription that results from these practices (and thus from the operationalization of grief), Stegenga advocates for “shifting our attention away from the magic bullet model of medical intervention,” instead prioritizing non-invasive, preventative, more wholistic, or generally more “gentle” modes of care (Stegenga, 2018, p.198). In other words, not only might the pathologization of grief have been influenced by the development of these treatment methods; the continued implementation of these methods, particularly among grieving individuals, has the potential to exacerbate pain and risk serious harm to bodies and psyches ⁴ (Stegenga, 2018). These realities affirm the importance of closely examining our path to the present. The path of grief to its modern manifestations as decontextualized diagnosis become far clearer when traced through this era: the process of operationalization, as a product and a tool of an outward-looking, calculating, and intervening clinical gaze, played a significant role in the medicalization and pathologization of grief, and continued reliance on these measures only reemphasizes the power-over-knowledge at work.

⁴ I must affirm, again, that such interventions are helpful and necessary for some individuals; statements like this are not meant to undermine pain or discourage use of treatment when needed. Rather, I hope to point out that the prescription of medications for bereaved individuals was in no way inevitable, and that the processes of medicalization and operationalization play a key role in the development of this reality.

Operationalization as Tool and Product

In this section, I will explore the dynamic role that measures played in transforming grief in this period. I will discuss a concept that arose from the data, experimenter's regress, as well as those mentioned in the literature review, data inertia and dynamic nominalism. In exploring the fit of these concepts with the data, I hope to better understand the nature of the relationship between operationalization and medicalization in this context.

Data Inertia. As mentioned in the literature review, Sally Engle Merry introduced the concept of "data inertia," arguing that the process of quantification requires decisions about what data matters and enacts decontextualization of that data (Merry, 2016, p.27; Berman & Hirschman, 2018). These reduced concepts then shape the possibilities for future iterations of quantification, increasingly narrowing or altering the meaning of a concept (Merry, 2016; Berman & Hirschman, 2018). In 1975-1995, there were a few instances wherein data inertia may have been at work – for example, many authors used items from previously published measures in the development of new measures. This claim can be made with most certainty about the Texas Inventory for Grief and the Grief Experiences Inventory, as they were both used in a variety of contexts, both to measure grief and to create future measures. It is also likely that data inertia was at work in the pockets of research on specific populations or specific diagnoses – for example, among survivors of perinatal loss or in creating the diagnosis of complicated grief. However, because much of this era's research was driven by various desires to challenge theories or to create new or more specified conceptualizations of grief, the concept of data inertia does not apply to the larger-scale threads of changes suggested by the corpus.

If the concept of data inertia is opened up to include operationalized definitions for grief (not merely quantitative data), then it does apply more clearly. Because nearly all measures were constructed using the findings of earlier research, if not already-constructed measures, choices about the contents of measures were limited by previously made decisions. This may have contributed to the increasing narrowness of the definitions for normal grief. In sum, though the concept of data inertia helps us to understand the possible transformation of knowledge in some subsets of this data, and the possibility of increasing narrowing of operationalized definitions developed in this timeframe, it can only partially speak to our understanding of the data as a whole.

Experimenter's Regress. Similar to data inertia, the concept of experimenter's regress was developed in the context of debates about physics and has primarily been applied in the physical sciences since. One author describes experimenter's regress as the idea that "an instrument is deemed good because it produces good results, and vice versa" (Perovic, 2017, p.313). Most technologies and tools of measurement are developed using hypotheses about the results they will reveal, and thus they are incapable of revealing results beyond the frame of the hypothesized (Perovic, 2017).

I argue that it is important to consider experimenter's regress in the social sciences as well as the physical. This concept can be seen at work throughout the development of measures for grief, particularly in the tautologies employed in their use and validation. As mentioned in the results, the first inventory for grief described the process of measure validation as also to "evaluate existing grief theory" and "necessarily ... validat[e] the construct of grief itself" (Faschingbauer, 1977, p.697). The rationales for use and development of multiple later measures reflected these instincts, many describing their goals of "better understand[ing]" grief, "better delineat[ing] the boundaries between normal and complicated" grief, and proving the multidimensionality of grief. Multi-factor analyses may have been helpful in identifying individual items that did not evidence significant correlations with other individual factors. However, when measures were constructed using a certain definition for grief or pathological grief, or a certain form of multidimensionality, it seems impossible that any data collected by the measure could provide substantial evidence against the construct.

The decisions at work in this data – and particularly the application of operationalization – reveal the way that the realm of possible conceptualizations for grief was not only limited within measures, but was kept from upheaval by the continued use of measures. That a tool would be used to test the validity of the definition or hypothesis on which it is constructed seems inherently ineffective, and the presence of experimenter's regress throughout the corpus speaks powerfully to the movements and stabilities of grief studies in this era.

Dynamic Nominalism. I will close this portion of analysis with an exploration of a theory that builds on processes like experimenter's regress. As mentioned briefly in the literature review, Ian Hacking proposed the delineation between 'natural kinds,' or naturally existing entities, and 'human kinds,' categories that have been constructed to make sense of observations, particularly in the social

sciences (Granek, 2010; Hacking, 1995). Hacking narrates the construction of human kinds as a boundary-sketching in response to the desire to count observed trends (Hacking, 1990; Hacking, 2004). Moreover, not only does “social change creat[e] new categories of people” in the incentive to organize and count, but “counting ... creates new ways for people to be” (Hacking, 2004, p.100). In other words, individuals, once assigned a category, might respond by changing behaviors in order that they be “comprehensible and practicable” according to the label, or to gain access to resources made available in the process of labelling (Sugarman, 2009, p.6; Hacking, 2004). This, in turn, changes the content of the category, initiating a loop of delineating, reacting, and redescribing which Hacking terms dynamic nominalism (Hacking, 2004).

Scholars have examined the process of dynamic nominalism in many settings, particularly with psy-discipline constructs. They have shown, for instance, how iterations of epidemiological research and cultural conceptions evidence a shift in genetic delineations of autism resulting in “diagnostic expansion” (Navon & Eyal, 2016, p.1416), and how implementation of a personality assessment shapes the performance of leaders into their identified strengths (Wardell & Fitzgerald, 2019). Most notably in thinking with grief, one set of scholars noted that the uptake of categorical constructions need not be by those categorized themselves, but could also be by those surrounding the categorized, who in turn communicate category-based expectations (Navon & Eyal, 2016).

Might our understanding of grief in this era fit this form, that of a “[kind] of human being... and human [act that has] come into being hand in hand with our invention of the ways to name them” (Hacking, 2004, p.113)? While I certainly cannot claim that the name for grief was new to this era, this data has shown that grief, as a category articulated by the psy-disciplines (and particularly as something which takes normal and pathological forms), was developed in these years. Further, I must note that this discussion is limited in that there is minimal evidence in this data on the reactions of grieving individuals to the process of labelling. However, in addition to the involvements of grieving individuals in validating definitions, which I will describe below, I think that, following Navon and Eyal’s claims, the larger cultural pulls of the moment played a role in communicating category-based expectations and therefore speak powerfully to reception of and reaction to labels.

In thinking with the looping of dynamic nominalism as it intertwines with this data, I argue that a number of interacting motives were at work in the reconceptualization of grief. The psy-disciplines as a whole were, as discussed, applying newly scientific modes of examination and theory in an effort to earn categorical respect as a medical discipline (Whooley, 2019; Granek, 2010). Moreover, multiple powers at work in the larger cultural sphere, most notably emphasis on scientific progress, neoliberal ideals of positive efficiency, and pharmaceutical treatment of (risks of) pain, produced an increasing pathologization of (emotional) pain, as evidenced in the literature and the data (Berlant, 2011; Ehrenberg, 2010; Dumit, 2012). Manifestations of these powers included the marketing of pharmaceuticals to treat physical and emotional pain (Graham, 2011; Shorter, 1997; Dumit, 2012) and the increasing claims that death and pain were taboo (Laqueur, 2015). As discussed, the latter of these likely goes hand-in-hand with the knowledge-power acquisitions of the psy-disciplines, seeking to control via medicalization experiences previously cared for in communal or cultural contexts.

The entry of measures into these broader knowledge-power movements is, I argue, crucial to an understanding of the dynamic production of grief. This data has shown that a network of interdependence goes into the validation of measures, as discussed in the argument for experimenter's regress. It has shown that operationalized definitions for grief rely primarily on previous research constructed among participants who were likely exposed both to the broad cultural pathologization of pain and to targeted medical interventions for grief. These definitions were then validated by redistributing measures into the grieving populous, a process which served to 1) only affirm the purported objectivity of the constructs because of experimenter's regress, and 2) redistribute a specific set of definitions and labels among the grieving populous and larger culture. The changes in grief over this timeframe and beyond suggest the possibility that the grieving populous re-ingested these definitions and shifted their performance of categorical grief accordingly in order to align with 'norms,' to access important insurance- or nosology-based resources, or to make legible their own experiences amid a culture that offered increasingly limited articulations of them. This process likely repeated iteratively – and continues to loop. Hacking describes how, on account of resource-access, self-legibility, performance into normality, or other reasons, a human kind is disseminated over time

and taken up by increasing populations (Hacking, 2004). As a result, the meaning of the kind may expand (Hacking, 2004). The increasingly broad definition of pathological grief, as well as the reification of normal grief, provide evidence of this in the instance of grief, and thus support the notions of a dynamic relationship. Therefore, in developing tools that purported to define medical objects and in using the responses on these tools to confirm scientific constructs for grief, the psychodisciplines disseminated labels onto the populous, shaped a culture in which the populous acted in reference to these labels to various degrees and for various internal and external motivations, and reformed their constructs of pathology/normalcy accordingly.

The development of one measure, the 1995 Inventory for Complicated Grief (ICG), provides more blatant evidence for the possible looping involved in construct development. While this is only one measure, it is particularly notable because it was referenced by other articles. Also, though they were only beginning their studies in this timeframe, the team that developed the ICG are now among the most prominent in grief studies and led the charge for the integration of this same (though renamed) pathological grief into the DSM in late 2021 (Kecmanovic, 2021). Strikingly, this team, in seeking to create a measure for ‘complicated grief,’ did not bring with them preexisting theories or definitions for the pathology, which they argued was discrete (Prigerson et al., 1995). Instead, they constructed the measure – and with it, the definition of complicated grief – by combining those items on previously distributed grief measures which were most likely to predict poor outcomes (Prigerson et al., 1995). The looping in this instance seems undeniable, as the definition of a ‘new’ pathological grief was constructed from the populous’ responses on previously constructed and distributed measures, and was in turn redistributed as the scientific discovery of a human kind, increasingly expanded and reified through decades.

Even as it is important to understand the ways in which grief’s operationalization looped with its medicalization, it is also important to consider the implications of dynamism. Most importantly, the dissemination of human kinds among both experts and the general public serves to reify the kind among both populations and, because of the seductiveness of quantification and the imperialism of expertise, create the kind as an objective or empirical category. In other words, because of the power at work in dynamic nominalism, and despite the clear presence of change in meaning and mode of

conceptualization, the fact that human kinds, “composed as they are of letters, ... have no other reality than the order of their composition” is silenced (Foucault, 1994, p.118). Hacking argues that exploration of dynamic nominalism is important in that “it contends that our spheres of possibility, and hence our selves, are to some extent made up by our naming and what that entails,” thus making urgent careful examination of the “origin[s]” of kinds (Hacking, 2004, p.113). In building future research off of data gathered using these categories and validated operationalized measures, the definitions of grief produced in dynamic nominalism determine the questions and findings of further research, thus shaping complex “dynamic entanglements” of knowledge production (Navon & Eyal, 2016, p.1460). Moreover, there are stakes for the creation and malleability, the looping, of human kinds beyond the philosophical or the methodological: diagnostic categories, in the post-DSM-III psy-discipline context, form the basis of systems of communication, treatment, financial support, and research among pharmaceutical, academic, medical, and insurance institutions, as well as the public. It is necessary that we understand the looping path to present conceptualizations, therefore, in order that we acknowledge the power in measure dissemination and fairly grapple with the decisions producing systems that impact the daily lives of significant populations.

In sum, I argue that both the overall trends in this timeframe and the specific instance of the ICG suggest that grief, particularly in its normal and pathological forms, was continually shaped in dynamic nominalism, and that the development and dissemination of quantitative measures served as the tool by which this was enacted. This is important to recognize not only because it sheds light on the process by which a now-formal diagnosis was created, but also because it reveals the larger and more dynamic role that operationalization plays in the medicalization of human experience. Based on these data and claims, I therefore argue that operationalization is not the inevitable product of a linearly progressive medicalization, but that the development and use of measures serves to strengthen and shape the path of medicalization, impacting both the content of medical categories and the expression of those labelled.

Limitations

A number of limitations in the methods of analysis must be reiterated. First, critical discourse analysis is particularly prone to influence by researcher perspectives and confirmation bias, and I do not claim to be free from these subjectivities. By relying on the process of grounded theory, I prioritized intentional reading of the selected articles to minimize projection of theoretical frameworks onto understandings and instead allow the data to speak directly to the analysis and conclusions. In this process, I did not seek objectivity, because that is inherently unattainable; instead, I aimed to present an analytical narrative that was, first, representative of and rooted in the data and, second, empathetic to the dynamic and relational implications of operationalization.

Particular sources of bias may have entered throughout the process. For instance, the information included in the literature review contained many perspectives that served to foreground my understandings of grief and psychiatry in addition to their role in this paper. These perspectives may have shaped by attunement to certain trends and analytical decisions. Further, even as the codebook was developed as guided by trends in the data, I may have been drawn to certain extremes or anticipated modes of thought in selecting what data to include in each code. In analyzing the smaller selections of coded data, as noted, trends may have appeared more consistent or significant than if otherwise diluted by all of the text in the corpus, introducing the bias of detail-overrepresentation. Moreover, while I attempted to observe moments wherein possibilities were silenced or left out, this process may have also been dampened or biased because of this coding method's orientation to details. Finally, I have tried to explain in detail each step of analysis, and particularly the iterative processes of coding and of combining trends into threads and threads into theories, in order that my decisions, assumptions, and influences be evident. These steps were particularly prone to bias and, even as I worked to prioritize the data, I do not hesitate to claim subjectivity.

Future Directions

There are many possibilities for further research based on the discussions here. First, in understanding the possible role of dynamic nominalism in the reification of grief, further research

should explore the discourse, behaviors, and beliefs of the grieving populous as they have been impacted by medicalization and operationalization. This might include ethnographic work among groups of bereaved in the present (e.g., resulting from the rapid dissemination of DSM-5-TR into the public) to examine the internalization of new conceptualizations, or archival research on the discourses of these groups between 1975-1995 to understand the impacts of the processes explored here. Further research designs could also be attuned to the possibilities silenced in medicalization and operationalization. The work of alternative conceptualizations that have persisted alongside medicalization or those that have been created to intentionally grapple with it might allow for a better understanding of the non/inevitability of reification.

Further, a few specific trends appeared in this data that merit clarification through further research. For example, the inconsistent blurring and separating of grief from experiences of (major) depression was notable, but not clear enough in this data to draw conclusions on exact patterns and mechanisms. Future research oriented to the use of ‘depression’ and ‘grief’ might be able to make sense of the tangling. Additional small trends noted here, such as the creation of a categorical normal and the increasing refinement of ‘resolution,’ would benefit from more extensive research.

Finally, the alignment of the trends in this data with dynamic nominalism, and its importance in understanding the history of the present, are important. Further research might explore other psychiatric diagnoses or disease categories in order to understand how the processes of medicalization and operationalization may interact beyond the concept of grief. Each of these explorations is important in that they might shine light on the processes that created the possibility for today’s conceptualizations of grief and other experiences.

Conclusion

How, in just over a century, could we travel from statements that “it never occurs to us to regard [mourning] as a pathological condition and to refer it to medical treatment” (Freud, 1953, p.243) to popular cultural invitations to “answer the [nine] quiz questions below to see [if you’re suffering from complicated grief disorder]” (Carranza, 2022)? The goal of this research has been to explore the ways in which the psy-disciplines shaped grief into a narrowly articulated object

that not only could, but must, be measured, tracked, and treated. By closely examining psy-discipline discourse published about grief between 1975 and 1995, I have argued that three key threads appeared in this timeframe: grief became the object of a newly medical psychiatry, research increasingly emphasized understanding and prediction of grief according to its multidimensionality, and grief was reified and pathologized. Many aspects of these key threads support previously published research, particularly the work of scholars such as Leeat Granek and Julia Bandini on the progressive medicalization and pathologization of grief (Granek, 2010; Granek, 2012; Bandini, 2015). While attention has not been given in previous research to the increasing emphases on grief's multidimensionality and predictability or the creation of 'normal' grief, for example, these ideas were supported by general discussion of grief's medicalization, as well as that of the process of medicalization and quantification in other contexts (Granek, 2010; Hacking, 1990; Merry, 2016; Dumit, 2012). In this way, the core threads of findings align closely with much of the published work on the history of grief.

The key aspect of this project that differed from previous studies was attunement to the role of operationalization in grief's medicalization. For example, while some previous work on the influence and use of operationalization – particularly Hacking's on controlling uncertainty – was supported by the data, I argue that it is necessary that these concepts be considered within cultural changes and claims of knowledge-power that occurred in medicalization. Further, the data suggested that operationalized definitions and quantitative measures for grief played key roles in each of the concluding threads, particularly as the tools through which the calculating and surveilling clinical gaze was enacted, and that these processes frequently entailed experimenter's regress. While not previously well-established in grief studies, aspects of these findings align with those produced in other contexts, such as on the gaze involved in the dissemination of measures for depression, post-traumatic stress, and generalized anxiety (Horwitz & Wakefield, 2007; Horwitz & Wakefield, 2012).

Moreover, because of the seductive power of quantification in the U.S., claims of grief's articulation within the psy-disciplines were cemented through the creation of operationalized definitions and measures for the construct (Merry, 2016; Hacking, 1990). The data showed that

measures were used both to acquire information about grief, narrowly defining and expansively pathologizing the experience, and to disseminate this information into the populous. I have argued that measures were and continue to be shaped by dynamic nominalism. This argument moves beyond that of previous literature on the power of quantification in creating perceived objectivity, and it challenges the idea that operationalization is a natural step in the linear medicalization of grief (Merry, 2016; Granek, 2010). It is necessary that we critically consider the knowledge produced in the creation of measures, and the power exerted in their dissemination, application, and reformation, if we are to understand the history of modern grief.

Significant power is at work in the very acts of defining an experience as ‘normal,’ as articulable within the language of the psy-disciplines, and as measurable. None of these decisions was inevitable, and yet they are the assumptions that form the foundations of modern psychiatric research and care. As discussed, each of these claims has important implications that have been silenced in many narratives of expertise. First, in claiming grief as an object only to be examined with their language and treated with their tools, the psy-disciplines silenced the role of cultural, communal, or non-medical modes of mourning and articulating grief, thus denying humans historically important healing. Further, the data supported previous claims (Granek & Peleg-Sagy, 2015) that the theories and samples used to develop these definitions were primarily those of white/European populations of high education and socioeconomic status, despite established cross-cultural, communal, and contextual differences in grief experience (Rosenblatt, 2017; Cheng, Ma, & Lam, 2019; Eng & Han, 2019; Rabins et al., 2019). This means that, when distributed as objective, limited articulations of normalcy have the potential to identify as pathological that which does not conform, colonizing expressions of grief through medical discourse, diagnosis, and treatment (Kinghorn, 2013). Further, particularly in light of grief’s recent addition as a diagnostic category in the DSM-5-TR, and because of the significant role that pharmaceutical companies play in driving research, chemically treating disorder experiences, and raising awareness about disorder constructs among the public, individuals experiencing grief that strays from ‘normal,’ or those grieving losses deemed negligible, may be diagnosed according to abbreviated measures and perpetually prescribed questionably-efficacious and potentially-harmful medications (Bandini,

2015; Granek, 2010; Dumit, 2012; Stegenga, 2018; Healy, 1999; Bishop, 2011). While grief is an immensely painful experience, and medical care and chemical treatment are important for some individuals experiencing grief, the current reliance on operationalized definitions for ab/normalcy creates risks of overdiagnosis and of the implementation of unnecessary interventionist methods (Stegenga, 2018; Bandini, 2015; Rose, 2003). Further, because of the processes of dynamic nominalism at work, operationalized definitions and measures for grief shape the ways in which it can be interrogated, thus iteratively expanding research within narrow conceptualizations while precluding the possibility of challenges to grief's very psy-articulation and measurability.

The findings of this project therefore urge interrogation of the psy-disciplines on the very claim that "social phenomena can be measured" (Espeland & Stevens, 1998, p.315). In the path toward a present where grief is diagnosable and where research is conducted on grief at the level of decontextualized symptom severity, intentional decisions over power and knowledge have been enacted, and they have been presented as sensible progress (Kecmanovic, 2021; MacCallum et al., 2021; Kuhn, 1996; Granek, 2010). We must pay attention to the intertwining of psychiatry's history with processes of seductive quantification, experimenter's regress, and dynamic looping, particularly in the creation of modern grief. It is critical that we, in seeking to better understand the practices enacted in the present, pay attention not only to the uses of tools, but to their very construction and dissemination, to the silencings and decisions they perform and to the lived realities they produce.

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Appendices

Appendix 1: Tables and Figures

Table 1. Number of Authors

Number of Authors	Number of Articles (Percent)
1	37 (52.9%)
2	17 (24.3%)
3	8 (11.4%)
6	8 (11.4%)
9	1 (1.4%)

Table 1 shows the dispersion of number of authors in each publication.

Figure 2. Publication Years of Articles Included

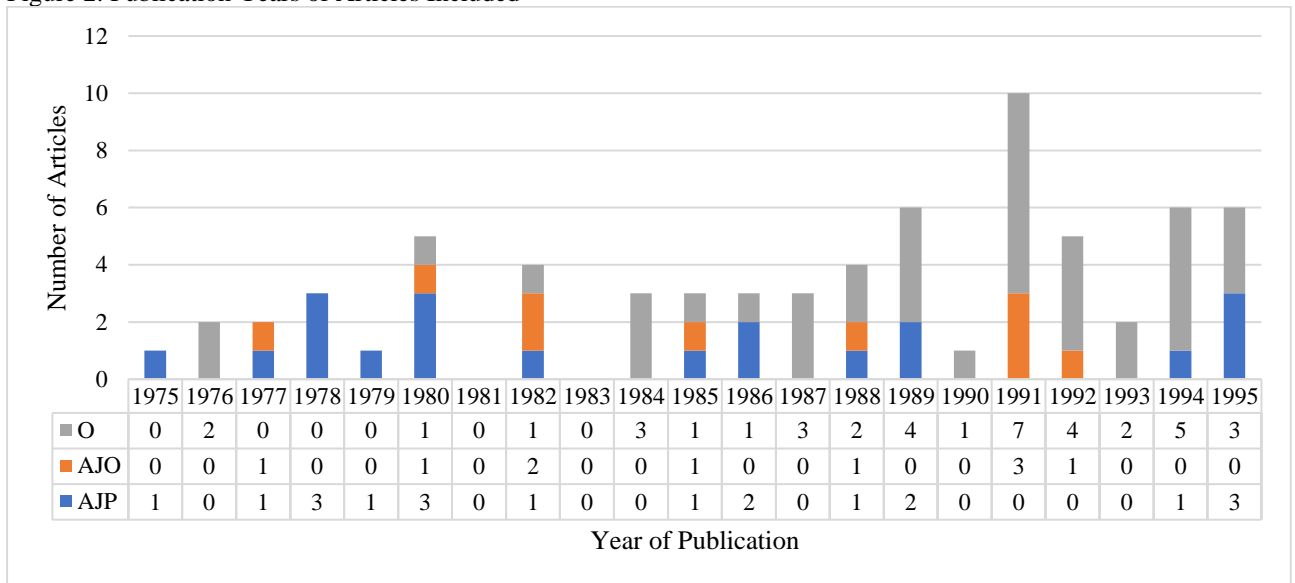


Figure 2 shows the number of articles published in each publication each year of the timeframe.

Figure 3. Genres of Articles in Each Journal

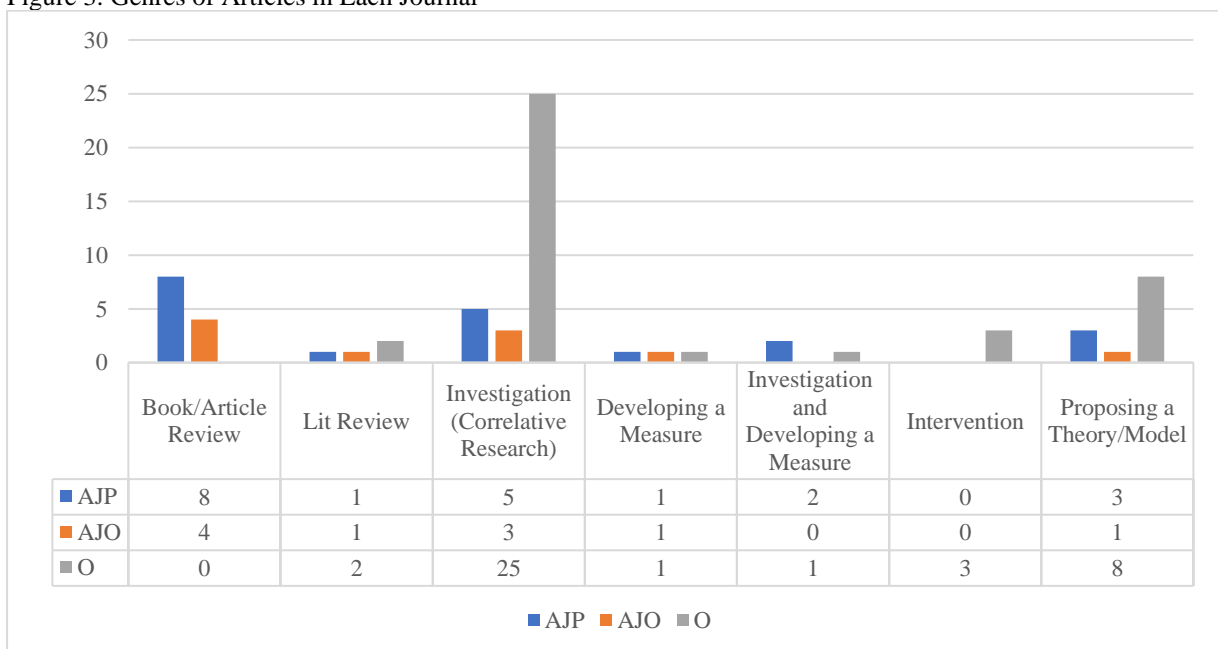


Figure 3 shows the genres of the articles in each publication.

Figure 4. Genres of Articles Over Time

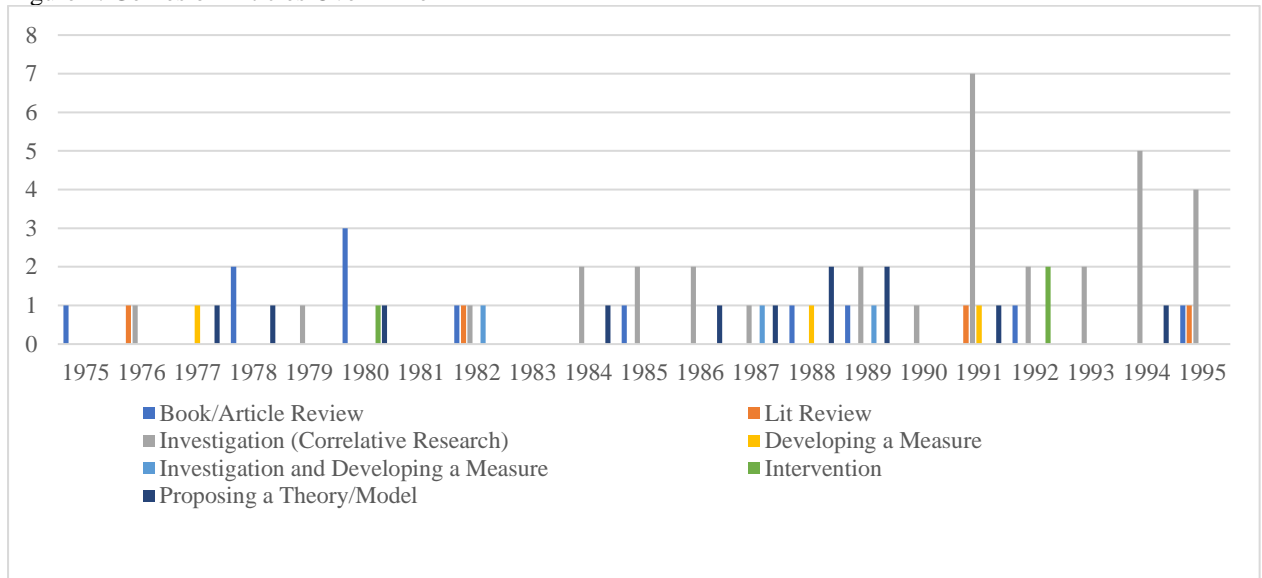


Figure 4 shows the genres of the articles across the timeframe.

Appendix 2: Citations of Dataset

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Appendix 3. Codebook

1. Defining grief: Content

- 1a. Content of definition
- 1b. Factors in understanding/studying grief
 - 1b1. Race/gender/age
 - 1b2. Object lost
 - 1b3. Type of loss
 - 1b4. Role of institutions or rituals – religious, medical, community
 - 1b5. Time since loss
 - 1b6. Individuality
 - 1b7. Other
- 1c. Definition of pathological Grief
- 1d. Definition of another Grief phenomenon (i.e., anticipatory; mourning)
- 1e. Recovery

2. Defining Grief: Mode

- 2a. Normal Mode
 - 2a1. Physiological/symptoms
 - 2a2. Psychoanalytic
 - 2a3. Psych – vs mourning, etc.
- 2b. Pathological Mode
 - 2b1. Physiological
 - 2b2. Psychoanalytic
 - 2b3. Dimension
- 2c. Pathological Explanation
 - 2c1. Dimension
 - 2c2. Discrete
 - 2c3. Interruption
 - 2c4. Other
- 2d. References to depression
 - 2d1. Part of / overlap
 - 2d2. Separate entities
- 2e. Short vs. long term effects
- 2f. Reference to a model
- 2g. Definition trends
 - 2g1. “normal”
 - 2g2. “multidimensional”
 - 2g3. “construct”
- 2h. Explanatory trends
 - 2h1. Use of metaphor, comparison, medical language
 - 2h2. Presence of anecdotes/narratives

3. Purpose of study / of studying grief

- 3a. type of research question
 - 3a1. Intervention
 - 3a2. Explore mechanisms
 - 3a3. Other
- 3b. Purpose for research
- 3c. Grief as un/controllable
- 3d. Site of intervention

4. Measure: Purpose for use or development

- 4a. Quantify
- 4b. Diagnose/separate from other phenomena
- 4c. Predict/correlate

- 4d. Intervene
- 4e. Lack of or weaknesses in previous research

5. Measure: role within study

- 5a. Grief measures used and why
- 5b. Other dx measures used and why
- 5c. Developing a measure: process
 - 5c1. Use of previous measures
 - 5c2. Qualitative/interview
 - 5c3. Other
- 5d. Type of measure
 - 5d1. Point scales
 - 5d2. Categories
 - 5d3. What is healthy/normal
 - 5d3. Interview/qual used as data

6. Context

- 6a. Mentions of tabooing death, cultural perceptions
- 6b. Grief is in whose domain?
- 6c. Attitude toward previous research or different models
- 6d. Culture of grief studies

7. Research cited

- 7a. Kubler Ross
- 7b. Lindemann
- 7c. Freud
- 7d. Bowlby
- 7e. Parkes
- 7f. Feifel
- 7g. Other

8. Descriptive

- 8a. journal
- 8b. date
- 8c. word count
- 8d. info about author/s – number of authors, maybe credentials
- 8e. type of piece – opinion, research article, meta study, etc.